STATE OF MICHIGAN
IN THE SUPREME COURT

JOHANNA WOODARD, Individually and as Next Friend of AUSTIN D. WOODARD, a Minor, and STEVEN WOODARD,

Plaintiffs-Appellees/
Cross-Appellants

vs.

JOSEPH R. CUSTER, M.D.,

Defendant-Appellant/
Cross-Appellee

and

MICHAEL K. LIPSCOMB, M.D., MICHELLE M. NYPAVER, M.D., AND MONA M. RISKALLA, M.D.,

Defendants

Supreme Court No. 124994
Court of Appeals No. 239868
Washtenaw County Circuit Court
Case No. 99-005364-NH

JOHANNA WOODARD, Individually and as Next Friend of AUSTIN D. WOODARD, a Minor, and STEVEN WOODARD,

Plaintiffs-Appellees/
Cross-Appellants

vs.

UNIVERSITY OF MICHIGAN MEDICAL CENTER,

Defendant-Appellant/
Cross-Appellee

Supreme Court No. 124995
Court of Appeals No. 239869
Court oClaims
Case No. 99-017432-CM

AMICUS CURIAE BRIEF OF MICHIGAN STATE MEDICAL SOCIETY

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STATEMENT OF BASIS FOR JURISDICTION

This case is before the Court pursuant to a July 12, 2005 Order granting leave to appeal.

STATEMENT OF QUESTIONS PRESENTED

I. Whether a standard of care expert who is board certified in pediatric medicine, specializes in genetics and, in the year preceding the alleged malpractice, allegedly devoted the majority of his professional time to "clinical patient care" as director of medical affairs at a facility for developmentally disabled children is qualified under MCL 600.2169(1)(a) and (1)(b)(i) to testify against a defendant physician who is board certified in pediatrics, specializes in pediatric critical care medicine and has certificates of added qualification in pediatric critical care medicine and perinatology/neonatology.

Plaintiff/Cross-Appellant says "yes."
Defendant/Cross-Appellee says "no."
Amicus Curiae MSMS says "no."

II. This Court has also directed the parties to address: (1) what are the appropriate definitions of the terms "specialty" and "board certified" as used in MCL 600.2169(1)(a); (2) whether either "specialty" or "board certified" includes subspecialties or certificates of special qualifications; (3) whether MCL 600.2169(1)(b) requires an expert witness to practice or teach the same subspecialty as the defendant; (4) whether MCL 600.2169 requires an expert witness to match all specialties, subspecialties, and certificates of special qualifications that a defendant may possess, or whether the expert witness need only match those that are relevant to the alleged act of malpractice; and (5) what are the relevant specialties, subspecialties, and certificates of special qualifications in this case.

STATEMENT OF FACTS

The issues raised by this appeal involve the interpretation of a statute that governs the qualification of an expert witness to testify regarding the standard of care in a medical malpractice case against a *specialist.* The statute is part of the Michigan Tort Reform Act of 1993, P.A. 1993, No. 78, which was enacted as a follow-up to earlier tort reform legislation implemented in 1986. Michigan is one of over 30 states that have enacted expert witness qualification statutes.[1] The Michigan statute requires that an expert witness retained to give standard of care testimony for or against a defendant, specialize in the *same* specialty as the defendant if the defendant is a specialist; additionally, if the defendant-specialist is board certified, the expert must also be board certified in *that specialty*. MCL 600.2169(1)(a). Further, the expert must have *devoted a majority of his or her professional time to the active clinical practice of that specialty* and/or to *the instruction of students in the same specialty* during the year immediately preceding the occurrence that is the basis for the claim. MCL 600.2169(1)(b).

In this case, Plaintiffs allege that Austin Woodard was admitted to the University of Michigan Hospital pediatric intensive care unit ("PICU") when he was fifteen days old with respiratory syncytial virus. Woodard's Appeal Brief at 2. Plaintiffs allege that while in the PICU, Austin was intubated to provide respiratory assistance; further, an arterial line was placed in his right groin and a central venous catheter was placed in the area of his left groin. *Id* at 3. Austin was subsequently found to have "left and right femur fractures, with the left extending into the growth plate." *Id* at 4. "Plaintiffs have admitted they are unable to pinpoint the specific

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[1] Other states include: Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Idaho, Illinois, Iowa, Kansas, Louisiana, Maryland, Mississippi, Montana, Nevada, New Hampshire, New Jersey, North Carolina, Ohio, Oklahoma, Rhode Island, South Carolina, Tennessee, Texas, Virginia, West Virginia. *See http://www.ncsl.org* (National Conference of State Legislatures, *State Medical Malpractice Tort Laws*; National Conference of State Legislatures, *2005 Enacted Medical Liability Legislation in the States*).

medical maneuver(s) and/or procedure(s) in which the improper handling or misapplied force occurred to Austin ...," *Id* at 5, but allege that it occurred during Austin's stay in the PICU. Plaintiffs have sued Dr. Joseph R. Custer, among others, who was Director of the PICU and, according to Plaintiffs, Austin's attending physician. *Id* at 6.

Plaintiffs initially attempted to establish liability without expert testimony based upon the doctrine of res ipsa loquitor, but this Court rejected that manner of proceeding in a peremptory opinion rendered upon consideration of Defendants' Application for Leave to Appeal. *See Woodard v Custer,* 473 Mich 1; 702 NW2d 522 (2005). The present appeal questions whether Plaintiffs' proposed expert against Dr. Custer satisfies the requirements of the expert witness qualification statute. While both the proposed expert, Dr. Anthony Casamassima, and Defendant Dr. Custer are board certified in pediatrics, in the year preceding the alleged malpractice Dr. Casamassima allegedly devoted the majority of his professional time to "his work ... as the Director of Medical Affairs" at a facility for developmentally disabled children "confined to the practice of general pediatrics."[2] Woodard's Appeal Brief at 7-8. Dr. Custer, on the other hand, specializes in pediatric critical care medicine and has certificates of added qualification in pediatric critical care medicine and perinatology/neonatology. Plaintiffs acknowledge that Dr. Casamassima has "no training in critical care medicine." *Id* at 9.

On these facts, the Court of Appeals held that Dr. Casamassima was not qualified to testify as a standard of care expert against Dr. Custer. *Woodard v Custer,* 2003 Mich App LEXIS 2647 (2003),[3] *rev'd in part* 473 Mich 1; 701 NW2d 133 (2005):

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[2] Dr. Casamassima also specialized in genetics. In March 1998, Dr. Casamassima "changed careers and is now a practicing attorney." Woodward's Appeal Brief at 7.

[3] This and all other unpublished cases cited herein are attached to this brief for the Court's convenience.

> Because the basis of the action is grounded in pediatric intensive care, plaintiffs were mandated by § 2169(1)(a) to present an expert who possessed that specialization. Dr. Casamassima's clinical practice during the year immediately preceding the instant injury, §2169(1)(b), did not involve pediatric critical care medicine. Given that Dr. Casamassima acknowledged that he was unaware of the precise standard of care for the treatment of critically ill infants, it is clear that plaintiffs were required to present an expert witness who was.

Id. at *12.

Amicus Curiae Michigan State Medical Society ("MSMS") is a professional association that represents the interests of over 14,000 physicians in the State of Michigan. Organized to promote and protect the public health and to preserve the interests of its members in the practice of medicine, MSMS has a pervasive interest in assuring that standard of care witnesses be trained and appropriately credentialed in the fields in which they testify. MCL 600.2169 is designed to accomplish that purpose and was properly applied by the Court of Appeals in this case. MSMS urges this Court to affirm the Court of Appeals' decision, as set forth in more detail below.

SUMMARY OF THE ARGUMENT

The expert witness qualification statute unambiguously directs that a standard of care witness proffered to testify regarding the standard of care against a board-certified "specialist" must also be board certified and specialize in the "same" specialty as defendant, and have devoted a majority of his or her professional time to active clinical practice or instruction in that specialty. This directive can only be satisfied if the terms "specialty," "specialize" and "specialist" are accorded their commonly understood meanings, which connote "a medical practitioner who deals only with a particular class of diseases, conditions, patients" and "concentrates one's efforts in a special activity, field or practice." These well-accepted definitions are broad enough to encompass the particularized training, qualifications and practice areas that might sometimes be referred to as "subspecialties." To effectuate the intent of the statute, if the defendant more narrowly specializes, and is board-certified, in a subspecialty, the

proposed standard of care expert must also specialize, be board-certified, and devote the majority of his or her professional time to clinical practice or instruction in that subspecialty. Further, certificates of added or special qualification granted by national boards recognized by the American Board of Medical Specialties or the American Osteopathic Association are "board certifications" within the meaning of the statute.

ARGUMENT

STANDARD OF REVIEW

De novo review is accorded to questions of statutory interpretation. *Ayar v Foodland Distributors,* 472 Mich 713, 715; 698 NW2d 875 (2005); *Roberts v Mecosta County General Hospital,* 466 Mich 57, 62; 642 NW2d 663 (2002).

I. If the Defendant is a Board Certified Pediatrician Who Devotes a Majority of His Professional Time to the Active Clinical Practice of Pediatric Critical Care Medicine and Has Certificates of Added Qualification in Pediatric Critical Care Medicine and Perinatology/Neonatology, An Expert Who is Board Certified in Pediatrics but Does Not Devote a Majority of His Professional Time to the Active Clinical Practice of Pediatric Critical Care Medicine and Does Not Have the Same Certificates of Added Qualification is not Qualified Under MCL 600.2169 to Testify as to the Applicable Standard of Care.

The issue raised by this appeal involves the interpretation of a statute that governs the qualification of an expert witness in a medical malpractice case against a *specialist.* The statute, MCL 600.2169, requires that a standard of care witness for or against a defendant specialize in the *same* specialty as the defendant if the defendant is a specialist; additionally, if the defendant-specialist is board certified, the expert must also be board certified in *that specialty.* MCL 600.2169(1)(a). Further, the expert must have *devoted a majority of his or her professional time to the active clinical practice of that specialty* and/or to *the instruction of students in the same*

specialty during the year immediately preceding the occurrence that is the basis for the claim. MCL 600.2169(1)(b).[4]

The Legislature's determination that the reliability of expert testimony requires a precise match between the specialties, board certifications and devotion to practice specialties of the expert and the defendant reflects the stringency of real world practice. The rapid advancement of medical science has necessitated increasing efforts by the medical profession to insure that physicians are properly trained in their practice areas. This frequently requires multiple levels of specialized training and certification within a particular field of medicine. While some may refer to these increasingly particularized medical fields as "subspecialties," the nomenclature is merely a matter of semantics. Sub-specialties are, in fact, specialties.

Medicine has extensively evolved into specialty practice. The American Board of Medical Specialties ("ABMS") consists of 24 member boards which develop and utilize professional and educational standards for the training, evaluation and credentialing of physicians in their respective specialty areas.[5] The American Osteopathic Association has 18 approved specialty boards.[6] Hospitals rely upon the credentialing and certification procedures of these boards, as well as numerous other certifying boards, such as the American Board of Oral

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[4] MCL 600.2169(c) governs expert testimony against a general practitioner and requires that the expert, in the year immediately preceding the occurrence that is the basis for the claim, have devoted a majority of his or her professional time to active clinical practice as a general practitioner or to the instruction of students. Further, the expert witness requirements are incorporated into MCL 600.2912d, which requires that a complaint asserting a claim for medical malpractice be accompanied by an affidavit of merit that attests to the validity of the claim. The affidavit must be signed by a health care professional that the plaintiff's attorney reasonably believes to satisfy the requirements for an expert witness prescribed by MCL 600.2169. Defendants are also required to file a similarly executed affidavit of meritorious defense. MCL 600.2912d.

[5] http:/www.abms.org/member.asp.

[6] *See e.g.*, http://www.osteopathic.org

and Maxillofacial Surgery, the American Board of Clinical Neurophysiology, and the American Society of Echocardiography, to screen, select, appoint and award hospital privileges to physicians.

A physician who lacks the training, experience and certification required to be credentialed by a hospital to perform a certain procedure or to practice a particular specialty is certainly not qualified to articulate the standard which governs that procedure or specialty in a court of law, and MCL 600.2169 recognizes the reliability need for matching board certifications. But matching board certifications do not end the inquiry. The statute goes further. The expert must also *specialize* in the *same* field as the defendant and devote a majority of his professional time to *active clinical practice* or instruction in that *specialty*. These later requirements reflect the Legislature's recognition that matching board certifications in an umbrella specialty may not reflect the real world practice experience of the defendant and the expert. This case is illustrative. Dr. Custer and Plaintiff's expert, Dr. asamassima, are both board certified in pediatrics. However, while Dr. Custer possesses certificates of added qualification in pediatric critical care medicine and neonatology-perinatology, and devotes the majority of his professional time to the practice of pediatric critical care medicine, particularly as the Director of the Pediatric Intensive Care Unit at University of Michigan Hospital, Dr. Casamassima "specializes in genetics" and, in the year immediately preceding the alleged malpractice, was the Director of Medical Affairs at the Richmond Children's Center, a facility for developmentally disabled children.[7]

Pediatric critical care medicine and neonatal/perinatal medicine are among numerous practice specialties that are within the broad umbrella of, but distinctly different from, the more

[7] *See* Brief on Appeal of Plaintiffs/Cross-Appellants at 6-7.

general field of pediatrics. Other specialties certifiable by the American Board of Pediatrics include adolescent medicine, developmental-behavioral pediatrics, pediatric emergency medicine, pediatric endocrinology, pediatric gastroenterology, pediatric hematology-oncology, pediatric infectious diseases, pediatric nephrology, pediatric pulmonology and pediatric rheumatology.[8] The pediatric origin of these additional specialties does not make them the "same" as pediatrics or the "same" as each other. Having gone beyond the generality of a specialty in pediatrics, these additionally certified individuals have in fact become specialists in another field subject to different standards of care.

The "standard of care" is a key element to the prosecution and defense of a medical malpractice case. In Michigan, the standard of care applicable to medical malpractice actions has been codified. MCL 600.2912a (with emphasis added) provides:

> In an action alleging malpractice the plaintiff shall have the burden of proving that in light of the state of the art existing at the time of the alleged malpractice:
>
> (a) The defendant, if a general practitioner, failed to provide the plaintiff the recognized standard of acceptable professional practice or care in the community in which the defendant practices or in a similar community, and that as a proximate result of the defendant failing to provide that standard, the plaintiff suffered an injury.
>
> (b) The defendant, if a *specialist*, failed to provide the recognized standard of practice or care within that *specialty* as reasonably applied in light of the facilities available in the community or other facilities reasonably available under the circumstances, and as a proximate result of the defendant failing to provide that standard, plaintiff suffered an injury.[9]

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[8] https://www.abp.org/stats/numdips.htm

[9] In *Cox v Board of Hospital Managers for the City of Flint,* 467 Mich 1; 651 NW2d 356 (2002), this Court noted that the standard of care for specialists is frequently, but inaccurately referred to as a national standard of care. This Court explained:

> The plain language of subsection (b) states that the standard of care is that "within that specialty as reasonably applied in light of the facilities available in the

This standard must be established by an expert witness who is familiar with the customary practice of the relevant population of professionals. As this Court recognized in *McDougall v Schanz*, 461 Mich 15, 36; 597 NW2d 148 (1999), the expert witness statute essentially modifies the standard of care element "to require that proof of malpractice 'emanate from sources of reliable character as defined by the Legislature'", quoting then Judge Taylor's dissenting Court of Appeals opinion in *McDougall*, 218 Mich App at 518.

That wasn't always the case. Prior to 1986, MRE 702 was the sole determinant regarding the admissibility of expert testimony. At that time, the rule allowed a witness to give expert testimony if the witness was "qualified as an expert by knowledge, skill, experience, training, or education ..." [10] This standard gave Michigan courts fairly free rein to determine whether a proffered expert had the requisite familiarity with the standard of care to pass evidentiary muster. Indeed, familiarity with the standard of care was frequently articulated as the qualifying test.[11]

> community or other facilities reasonably available under the circumstances." ... Under the plain language of the statute, then, the standard of care for both general practitioners and specialists refers to the community."

Id. at 17 n 17.

[10] Amended effective January 1, 2004 to bring the admissibility of expert testimony in line with the federal standard established by the United States Supreme Court in *Daubert v Merrell Dow Pharmaceuticals, Inc*, 509 US 579 (1993), MRE 702 now provides:

> If the court determines that scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education may testify thereto in the form of an opinion or otherwise if (1) the testimony is based on sufficient facts or data, (2) the testimony is the product of reliable principles and methods, and (3) the witness has applied the principles and methods reliably to the facts of the case.

[11] *See e.g., Dybata v Kistler,* 140 Mich App 65, 69; 362 NW2d 891 (1985); *Bahr v Harper-Grace Hospitals,* 198 Mich App 31, 34-35; 497 NW2d 526 (1993) *rev'd in part on other*

While courts traditionally examined the *specialty* of the defendant when determining whether the proffered expert was qualified to testify under MRE 702, the absence of specific guidelines led to an obvious lack of uniformity. Some courts found that an expert who did not specialize in the same field as the defendant was not sufficiently familiar with the applicable standard of care to testify. *See e.g., Swantek v Hutzel Hospital,* 115 Mich App 254, 259; 320 NW2d 234 (1982)(pediatric neurologist could not testify as to the standard of care of an obstetrician-gynecologist); *Dybata v Kistler, supra* n.10, (obstetrician-gynecologist is not sufficiently familiar with the standard of care governing a general practitioner); *Carlton v St John Hospital,* 182 Mich App 166, 171-172; 451 NW2d 543 (1989)(even though witness need not specialize in the field he is asked to testify about, cardiologist was not qualified to opine whether performance of surgery violated the standard of care applicable to a surgeon); *Dunn v Nundkumar,* 186 Mich App 51, 54; 463 NW2d 435 (1990)(even though expert need not specialize in the field he is asked to testify about, general surgeon and family practitioner was unqualified to testify regarding the standard of care governing an obstetrician-gynecologist). *See also, Dengler v State Farm Mutual Ins Co,* 135 Mich App 645, 649; 354 NW2d 294 (1984)(proffered expert who was not a specialist in neurology was not qualified to testify regarding a subarachnoid hemorrhage).

However, other courts allowed expert witnesses to testify *even absent credentials or experience in the defendant's specialty. See e.g., Wolak v Walczak,* 125 Mich App 271, 276; 335 NW2d 908 (1983)(obstetrician-gynecologist may testify about the effect of bilirubin in newborns); *Strach v St. John Hospital Corp,* 160 Mich App 251, 273; 408 NW2d 441

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grounds 448 Mich 135 (1995); *Siirila v Barrios,* 398 Mich 576, 593; 248 NW2d 171 (1976); *Francisco v Parchment Medical Clinic, P.C.,* 407 Mich 325, 327; 285 NW2d 39 (1979); *Callahan v William Beaumont Hospital,* 400 Mich 177, 180; 254 NW2d 31 (1977).

(1987)(board certified general surgeon permitted to testify against a thoracic surgeon); *Banks v Wittenberg,* 82 Mich App 274, 277; 266 NW2d 788 (1978)(urologist can testify regarding the standard of care applicable to a general practitioner); *Wilson v W A Foote Memorial Hospital,* 91 Mich App 90, 101-102; 284 NW2d 126 (1979)(orthopedic surgeon permitted to testify regarding the standard of care of a hospital relative to the emergency nature of a breech presentation at birth); *Mazey v Adams,* 191 Mich App 328, 331; 477 NW2d 698 (1991)(internist with specialty in cardiology permitted to testify to standard of care of general practitioner); *Siirila v Barrios, supra,* and *Berwald v Kasal,* 102 Mich App 269, 276; 301 NW2d 499 (1980)(specialist may testify as to standard of care applicable to a general practitioner).

There was also a discrepancy in the requisite timeliness of the expert's knowledge. Some courts allowed experts to testify *despite their absence from the practice of medicine for a number of years. See e.g., Pietrzyk v Detroit,* 123 Mich App 244, 247-248; 333 NW2d 236 (1983)(medical doctor's 20-year absence from the emergency room setting did not preclude him from testifying about the standard of care in an emergency room); *Haisenleder v Reeder,* 114 Mich App 258, 265; 318 NW2d 634 (1982)(physician who had not practiced for 13 years in an emergency room setting was permitted to testify regarding the standard of care applicable to an emergency room physician). Other experts were disqualified because of their absence from practice. *Gilmore v O'Sullivan,* 106 Mich App 35, 39; 307 NW2d 695 (1981) (an expert who had not delivered a baby since 1959 nor performed surgery since 1967 could not testify regarding the standard of care applicable to an obstetrician-gynecologist).

Not surprisingly, these amorphous requirements for standard of care testimony led to a proliferation of circuit-riding "experts" who "practiced" only in the litigation arena. Their "pay-

for-what-you-want testimony" compromised the integrity of the judicial process and contributed to the malpractice crisis that prompted the need for tort reform.[12]

To address this problem, the 1986 enactment of MCL 600.2169 required that expert witnesses "actually practice" or "teach medicine" and have "firsthand practical expertise in the subject matter about which they are testifying." *Id.*[13] The 1986 version of the statute sought to

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[12] As the *Report of the Senate Select Committee on Civil Justice Reform* viewed the problem in Michigan:

> Testimony of expert witnesses is normally required to establish a cause of action for malpractice. Expert testimony is necessary to establish both the appropriate standard of care and the breach of that standard. There is currently no specific requirement for an expert witness to devote a specific percentage of time to the actual practice of medicine or teaching, or when testifying against a specialist that the expert actually practices or teaches in *that specialty*. Instead, a physician-witness is qualified to testify as an expert in Michigan, even though he/she does not practice in Michigan and is not of the same specialty, based on a mere showing of an acceptable background and a familiarity with the nature of the medical condition involved in the case. As a practical matter, in many courts merely a license to practice medicine is needed to become a medical expert on an issue.
>
> This has given rise to a group of national professional witnesses who travel the country routinely testifying for plaintiffs in malpractice actions. These "hired guns" advertise extensively in professional journals and compete fiercely with each other for the expert witness business. For many, testifying is a full-time occupation and they rarely actually engage in the practice of medicine. There is a perception that these so-called expert witnesses will testify to whatever someone pays the [sic] to testify about.

Id. at 28-29 (emphasis added).

[13] The *Senate Report* explained:

> In particular, with the malpractice crisis facing high-risk specialists, such as neurosurgeons, orthopedic surgeons and ob/gyns, this reform is necessary to insure that in malpractice suits against specialists, the expert witnesses actually practice in that same specialty. This will protect the integrity of our judicial system by requiring real experts instead of "hired guns."

Id. at 29.

do this by requiring that an expert testifying for or against a specialist, specialize in the same specialty *or a related relevant area of medicine* as the defendant in the action, and devote or have devoted at the time of the occurrence involved in the action, a substantial portion of his or her professional time to practice or teaching in that area.[14] The statute provided in relevant part:

> (1) In an action alleging medical malpractice, if the defendant is a specialist, a person shall not give expert testimony on the appropriate standard of care unless the person is or was a physician licensed to practice medicine or osteopathic medicine and surgery or a dentist licensed to practice dentistry in this or another state and meets both of the following criteria:
>
> (a) Specializes, or specialized at the time of the occurrence which is the basis for the action, *in the same specialty or a related, relevant area of medicine or osteopathic medicine and surgery or dentistry as the specialist who is the defendant* in the medical malpractice action.
>
> (b) Devotes, or devoted at the time of the occurrence which is the basis for the action, a substantial portion of his or her professional time to the active clinical practice of medicine or osteopathic medicine and surgery or the active clinical practice of dentistry, or to the instruction of students in an accredited medical school, osteopathic medical school, or dental school *in the same specialty or a related, relevant area of health care as the specialist who is the defendant* in the medical malpractice action.
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> * * *

Former MCL 600.2169 (emphasis added).

Although the 1986 statute tightened up the requirements for the qualification of experts, it became apparent that the statute had not gone far enough and that more restrictive reforms were necessary. Thus, the 1993 amendments require that the proffered expert be currently licensed to practice medicine, practice in the *same specialty* as the defendant, and be board certified in that *specialty* if the defendant was board certified. The revised statute further requires that the expert

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[14] The statute was part of the Michigan Tort Reform Act of 1986, P.A. 1986, No. 178.

devote the majority of his or her professional time to practice or instruction in that *specialty*. The statute, which is the statute presently before this Court, provides in pertinent part:

> (1) In an action alleging medical malpractice, a person shall not give expert testimony on the appropriate standard of practice or care unless the person is licensed as a health professional in this state or another state and meets the following criteria:
>
> (a) If the party against whom or on whose behalf the testimony is offered is a specialist, specializes at the time of the occurrence that is the basis for the action in the same specialty as the party against whom or on whose behalf the testimony is offered. However, if the party against whom or on whose behalf the testimony is offered is a specialist who is board certified, the expert witness must be a specialist who is board certified in that specialty.
>
> (b) Subject to subdivision (c), during the year immediately preceding the date of the occurrence that is the basis for the claim or action, devoted a majority of his or her professional time to either or both of the following:
>
> (i) The active clinical practice of the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, if that party is a specialist, the active clinical practice of that specialty.
>
> (ii) The instruction of students in an accredited health professional school or accredited residency or clinical research program in the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, if that party is a specialist, an accredited health professional school or accredited residency or clinical research program in the same specialty.
>
> * * *

In *McDougall v Schanz,* 461 Mich 15; 597 NW2d 148 (1999), this Court upheld the constitutionality of the expert witness statute as a valid exercise of the Legislature's public

policy-making prerogative, finding that the statute did not impermissibly infringe upon this Court's exclusive authority under the Michigan Constitution 1963, art 6, § 5. to promulgate rules governing practice and procedure in Michigan courts. Rather, this Court concluded that the statute was an enactment of "substantive law." 461 Mich at 18.[15] This Court explained:

> [W]e conclude that § 2169 is an enactment of substantive law. It reflects wide-ranging and substantial policy considerations relating to medical malpractice actions against specialists. We agree with the Court of Appeals dissent in *McDougall* that the statute
>
> > reflects a careful legislative balancing of policy considerations about the importance of the medical profession to the people of Michigan, the economic viability of medical specialists, the social costs of "defensive medicine," the availability and affordability of medical care and health insurance, the allocation of risks, the costs of malpractice insurance, and manifold other factors, including, no doubt, political factors – all matters well beyond the competence of the judiciary to reevaluate as justiciable issues. [218 Mich. App. at 518 (Taylor, PJ, dissenting).]

461 Mich at 35.

More recently, this Court considered the matching board certification requirement of Section 2169(1)(a) in *Halloran v Bhan*, 470 Mich 572; 683 NW2d 129 (2004). In that case, the proposed standard of care expert was board certified in anesthesiology and had a certificate of added qualification in critical care from the anesthesia board. The defendant physician was board certified in internal medicine with a certificate of added qualification in critical care from the Board of Internal Medicine. Thus, because the defendant and the expert were not board certified in the same specialty, the majority concluded that the expert was not qualified to testify under the plain meaning of the statute. 470 Mich at 579.

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[15] The 1986 version of the statute was before this Court in *McDougall*. However, this Court stated that its ruling applied with equal force to the 1993 statute. 461 Mich at 21, n 2.

In reaching this conclusion, the majority rejected the Court of Appeals' ruling that it was sufficient under the statute if the expert witness and the defendant doctor shared the same critical care sub-specialty, stating that "'in spite of' the specialty requirement in the first sentence [of Section 2169(1)(a)], the witness must also share the same board certification as the party against whom or on whose behalf the testimony is offered." *Id.* at 578. In the context of the *Halloran* decision, the majority did not decide the inverse issue which is presently before this Court - how the "same specialty" requirement is to be applied when the general board certifications match but the sub-specialty practice areas do not. The dissenting opinions did not reach this issue either. However, the issue was addressed in part by the Court of Appeals in the post-*Halloran* case of *McQuire v Wasvary*, 2005 Mich App LEXIS 119 (2005). In that case, the defendant and the expert were both board certified in general surgery. The defendant, however, was a fellowship trained colon-rectal surgeon and exclusively practiced in the area of colon and rectal surgery, which the defendant characterized as a sub-specialty of general surgery. Giving effect to the defendant's sub-specialty practice, the Court held that the expert was not qualified to testify against the defendant. The Court explained:

> Moreover, we note that *MCL 600.2169* does not define or distinguish between specialist and subspecialists. However, the dictionary defines "specialist" as "a person devoted to one subject or to one particular branch of a subject or pursuit." *Random House Webster's College Dictionary* (2d ed), p 1260. Applying this definition to the statutory language, *Halloran, supra*, reveals that there is no such distinction where a specialist is devoted to a subject or a particular branch within a subject. Accordingly, this attempted distinction is without merit.

2005 Mich App LEXIS at *14 n 4. *See also, Kirkaldy v Rim,* 251 Mich App 570; 651 NW2d 80 (2002), *vacated on other grounds*: 2004 Mich LEXIS 2599; 689 NW2d 228 (2004) where plaintiff alleged that defendant neurologists, both of whom were board certified, failed to diagnose and treat plaintiff's brain tumor. The affidavit of merit was signed by a board certified

neurosurgeon. The Court of Appeals agreed that the expert had to be a board certified neurologist.

Several other courts have also construed the statute to require a precise match. For example, in *Greathouse v Rhodes,* 242 Mich App 221, 231; 618 NW2d 106 (2000), *reversed on other grounds*, 465 Mich 885; 636 NW2d 138 (2001), the Court of Appeals deemed MCL 600.2169 to require "that the expert's practice, teaching and certification qualifications be precisely 'matched' with those of the defendant. Absent a proper 'match' the expert may not be presented in support of a litigant's case or defense." In *Kirkaldy*, 251 Mich App at 577, the Court of Appeals interpreted MCL 600.2169 to require that the expert practice or teach "in the same specialty as the defendant" and if the defendant is board certified in a specialty, "the expert must be board certified in *that same specialty."* (emphasis added). As the Court of Appeals saw it in *Decker v Flood,* 248 Mich App 75, 85; 638 NW2d 163 (2001), although the Supreme Court had repudiated the "absurd result" rule of statutory construction where the language of the statute is unambiguous, there was "no absurdity or unreasonableness in the requirement that the qualifications of a purported expert match the qualifications of the defendant against whom that expert intends to testify." Even the dissent in *McDougall* acknowledged that "the statute requires a specialist for specialist 'match-up' between witnesses and defendants." 461 Mich at 67 (Cavanagh, J, dissenting). *See also, Shenduk v Harper Hospital,* 1999 Mich App LEXIS 2571, *20 (1999)(Murphy J, concurring and dissenting)("As drafted, the statute clearly requires that when a defendant has board certification in a particular specialty an expert witness must hold matching board certification.") [16]

[16] A contrary conclusion was reached in the pre-*Halloran* case of *Watts v Canady,* 253 Mich App 468, 470; 655 NW2d 784 (2002), where the defendant physician specialized and was board certified in pediatric neurosurgery and the expert was a board certified neurosurgeon. In seeking

In this case, "specialty" incorporates the more refined specialty practice areas within the field of pediatrics and "board certification" includes certifications which demonstrate added qualification within specific pediatric specialty areas. The American Board of Medical Specialties publication "Which Medical Specialist For You" highlights the distinct nature of these pediatric specialty areas. "Neonatal/Perinatal Medicine" describes "a pediatrician who is the principal care provider for sick newborn infants..." "Pediatric Critical Care Medicine" describes "A pediatrician expert in advanced life support for children from the term or near-term neonate to the adolescent. This competence extends to the critical care management of life-threatening organ system failure from any cause in both medical and surgical patients, and to the

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summary disposition, defendants argued that because of the differing specialties, the expert was not qualified under MCL 600.2169(1)(a). Defendants also argued that the expert was not qualified under MCL 600.2169(1)(b) because he did not devote the majority of his professional time to active clinical practice or instruction in that specialty. The Trial Court rejected the assertion that plaintiff's expert had to be a pediatric neurosurgeon, finding that the expert's professed familiarity with the procedure was enough to engender a "reasonable belief" that "the right specialist has been found, especially as the statute uses the word 'specialist,' not 'sub-specialist.'" The Court of Appeals affirmed. As to the specialty issue, the Court said "We see no grounds for imposing a sub-specialty requirement when the Legislature has spoken in terms of a specialty requirement." 253 Mich App at 470. In yet another case, *Hamilton v Kuligowski*, 261 Mich App 608; 684 NW2d 366 (2004), lv granted, 473 Mich 858 (2005), the complaint alleged that defendant "failed to identify the decedent as a high-risk stroke patient, 'undertake a prompt work up' for stroke, and 'make an urgent referral' after the decedent experienced pre-stroke symptoms." 261 Mich App at 609. Defendant Dr. Kuligowski was board certified in, and practiced, internal medicine. The expert, Dr. Markowitz, testified that he was board-certified in internal medicine but had additional subspecialty training in, and devoted the majority of his medical practice to, infectious diseases. *Id.* at 609. Defendant moved to strike Dr. Markowitz because he did not devote the majority of his active clinical practice to the same specialty as Dr. Kuligowski. The Trial Court agreed that the active clinical practice requirement precluded Dr. Markowitz's testimony and entered a directed verdict for Dr. Kuligowski. *Id.* at 610. The Court of Appeals reversed, stating that it "declined defendant's invitation to graft a requirement for matching subspecialties onto the plain 'specialty' language of MCL 600.2169(1)." 261 Mich App at 611. As is more fully discussed below, a "subspecialty" is in fact a "specialty" within the meaning of the statute. MSMS thus believes that in each of these cases, the Court failed to apply the expert witness statute as written, but rather imposed its own policy preferences under the guise of judicial construction.

support of vital physiological functions. ..." *Id* at 24. The American Board of Pediatrics,[17] on the other hand, defines "pediatrics" and a "pediatrician," as follows:

> Pediatrics is the specialty of medical science concerned with the physical, emotional and social health of children from birth to young adulthood. Pediatric care encompasses a broad spectrum of health services ranging from preventive health care to the diagnosis and treatment of acute and chronic disease.
>
> Pediatrics is a discipline that deals with biological, social and environmental influences on the developing child and with the impact of disease and dysfunction on development. Children differ from adults anatomically, physiologically, immunologically, psychologically, developmentally and metabolically.
>
> The pediatrician understands this constantly changing functional status of his or her patient incident to growth and development and the consequent changing standard of "normal" for age. A pediatrician is a medical specialist who is primarily concerned with the health, welfare and development of children and is uniquely qualified for these endeavors by virtue of interest and initial training. Maintenance of these competencies is achieved by experience, training, continuous education, self assessment and practice improvement.
>
> A pediatrician is able to define accurately the child's health status as well as to serve as a consultant and to make use of other specialists as consultants. Because the child's welfare is heavily dependent on the home and family, the pediatrician supports efforts to create a nurturing environment. Such support includes education about healthful living and anticipatory guidance for both patients and parents ...

Quite clearly, the skills and training of a pediatrician are far more general that that of a physician more specifically trained to deal with sick newborn infants who require advanced life support and critical care management of life-threatening system failure. As a general pediatrician, Dr. Casamassima simply does not possess the same expertise, is not similarly "board certified" and cannot be deemed to engage in the same specialty as Dr. Custer. Thus the requirements of the expert witness statute were not met. The Court of Appeals in *Woodard* properly excluded

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[17] http:/www.abp.org/abpinfo/abouttheabp.htm

Dr. Casamassima's testimony. For reasons more fully explained below, MSMS urges this Court to affirm. [18]

A. The Rules of Statutory Construction Require that the Statute be Applied According to its Plain Meaning.

The foremost rule of statutory construction is that courts are to give effect to the legislative intent. *Halloran v Bhan,* 470 Mich at 576-577. This Court articulated and observed the applicable rules in *In re Certified Question, Henes Special Projects Procurement, Marketing and Consulting Corp v Continental Biomass Industries, Inc*, 468 Mich 109; 659 NW2d 597 (2003), a case certified by the Sixth Circuit to determine the standard for evaluating the mental state required to assess double damages under the Michigan Sales Representative Commission Act. In addressing its task, this Court explained:

> A fundamental principle of statutory construction is that "a clear and unambiguous statute leaves no room for judicial construction or interpretation." *Coleman v Gurwin,* 443 Mich 59, 65; 503 NW2d 435 (1993). The statutory language must be read and understood in its grammatical context, unless it is clear that something different was intended. *Sun Valley Foods Co v Ward,* 460 Mich 230; 596 NW2d 119 (1999). When a legislature has unambiguously conveyed its intent in a statute, the statute speaks for itself and there is no need for judicial construction; the proper role of a court is simply to apply the terms of the statute to the circumstances in a particular case. *Turner v Auto Club Ins Ass'n,* 448 Mich 22, 27; 528 NW2d 681 (1995).

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[18] The expert witness qualification statute was also before this Court in *Grossman v Brown*, 470 Mich 593; 685 NW2d 198 (2003). In that case, the issue was whether the plaintiff's attorney had a reasonable belief under MCL 600.2912d(1) that the expert who signed an affidavit of merit on plaintiff's behalf satisfied the expert witness requirements of MCL 600.2169a. The defendant was board certified in general surgery and possessed a certificate of special qualification in vascular surgery. The expert was board certified in general surgery and specialized (but did not possess a certificate of added qualification) in vascular surgery. The majority held that given the information available to the plaintiff's attorney when he prepared the affidavit of merit, he had a reasonable belief that the doctors were both certified in general surgery and that there was no board certification in vascular surgery. The majority did not, however, decide whether the expert would be qualified to testify at trial and expressly declined to consider the additional issue of whether board certifications must match in all cases or only those in which the board certifications are relevant to the alleged malpractice. 470 Mich at 600, n 7.

468 Mich at 113. *See also, Ayar v Foodland Distributors*, 472 Mich 713, 716; 698 NW2d 875 (2005) ("Clear and unambiguous statutory language is given its plain meaning, and is enforced as written"); *Eggleston v Bio-Medical Applications of Detroit, Inc,* 468 Mich 29, 32; 658 NW2d 139 (2003)("If the language of a statute is clear, no further analysis is necessary or allowed"); *Roberts v Mecosta County General Hospital,* 466 Mich 57, 63; 642 NW2d 663 (2002)("a court may read nothing into an unambiguous statute that is not within the manifest intent of the Legislature as derived from the words of the statute itself."); *Omelenchuck v City of Warren,* 461 Mich 567, 575; 609 NW2d 177 (2000)(refusing to rewrite the tolling statute to add words to the statute); *Sun Valley Foods Co v Ward*, 460 Mich. 230, 236; 596 NW2d 119 (1999)(the Court's primary task of discerning and giving effect to the Legislative intent "begins by examining the language of the statute itself"); *People v Herron,* 464 Mich 593, 611; 628 NW2d 528 (2001)("We must give the words of a statute their plain and ordinary meaning ....")(quoting *People v Morey*, 461 Mich 325, 329-30; 603 NW2d 250 (1999)); *Storey v Meijer, Inc*, 431 Mich 368, 376; 429 NW2d 169 (1988)("Legislative intent is to be derived from the actual language of the statute, and when the language is clear and unambiguous, no further interpretation is necessary.").

The judicial role "precludes imposing different policy choices than those selected by the Legislature." *The Herald Co v City of Bay City,* 463 Mich 111, 117; 614 NW2d 873 (2000). As this Court explained in *Hanson v Board of County Road Commissioners of the County of Mecosta,* 465 Mich 492, 504; 638 NW2d 396 (2002):

> [O]ur function is not to redetermine the Legislature's choice or to independently assess what would be most fair or just or best public policy.

Where the Legislature has not expressly defined common terms used in a statute, the Court may consider dictionary definitions to construe those words in accordance with their ordinary and

generally accepted meanings. *In re Certified Question,* at 113. A word or phrase also derives meaning from its context or setting. *The Herald Co, supra* at 131 n.10.

B. To Effectuate the Plain Meaning of the Statute, the Word "Specialist" and "That Specialty" in the First Sentence of MCL 600.2169 (1)(a) and MCL 600.2169(1)(b)(i) Must be Construed to Encompass the Defendant's Actual Practice Specialty.

The first enacted version of MCL 600.2169 permitted the proffered expert to specialize and practice in an area of medicine that was "related" and "relevant" to the defendant's specialty. This meant that a specialist in one field could testify against a specialist in another field "as long as the two fields were connected to each other and had practical value to one another and as long as the proposed expert practiced or taught in the associated, pertinent area of health care." *McClellan v Collar,* 240 Mich App 403, 410; 613 NW2d 729 (2000).

The 1993 amendment eliminated this leeway by requiring that the expert specialize in the same specialty as the defendant.[19] "Same" quite clearly does not mean related or relevant. "Same" means identical. *See e.g., Oxford English Reference Dictionary* (Rev. 2d ed, 2002)(defining same to mean "... identical; not different; unchanged ..."); *Webster's Universal College Dictionary* (2001)(defining "same" as "identical with what is about to be or has just been mentioned ...") As plainly understood, a defendant who specializes in pediatric critical care medicine and perinatology/neonatology, particularly as director of a pediatric intensive care

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[19] A change in the language used in a statute is presumed to reflect a change in its meaning. *Michigan Millers Mutual Ins Co v West Detroit Building Co, Inc,* 196 Mich App 367, 373; 494 NW2d 1 (1992). Indeed, this Court has characterized the 1993 statute as "more restrictive" than the 1986 version. *McDougall v Schanz,* 461 Mich at 21, n2. Other Courts have reached the same conclusion. *See e.g., McClellan v Collar,* 240 Mich App at 408 n. 2 ("The 1993 amendments are more restrictive than the requirements set out in the version of § 2169 that applies to this case"); *Shenduk v Harper Hospital,* 1999 Mich App LEXIS 2571 at *24 (1999)(Murphy J, concurring and dissenting)("the increased restriction of the current 1993 version, not allowing for specialists of a *related* discipline, indicates that strict adherence is intended.").

hospital unit, and an expert whose specializes in pediatrics and genetics as director of a facility for developmentally disabled children, do not specialize or devote a majority of their professional time to the "same" specialty. A contrary conclusion would turn the definition of "same" on its head.

Further, nothing in the commonly accepted meanings of "specialty" or "specialist" precludes attention to the more particularized fields within a designated practice area. Indeed, particularity is the hallmark of specialization. In *Cox v Board of Hospital Managers for the City of Flint,* 467 Mich 1, 18-19, *supra*, n 8, this Court quoted the *Random House Webster's College Dictionary* (1997), which defined specialist as "a medical practitioner who deals only with a particular class of diseases, conditions, patients, etc." *See also, Decker v Flood,* 248 Mich App 75, 83; 638 NW2d 163 (2001) (quoting same *Random House Webster's College Dictionary* (1997) definition, as well as the *Stedman's Medical Dictionary* (26th ed) definition which defines specialist as "one who devotes professional attention to a particular specialty or subject area.") A similar definition was employed in *Jalaba v Borovoy,* 206 Mich App 17, 22; 520 NW2d 349 (1994), where the Court of Appeals observed that a doctor is a specialist "on the basis of advanced training and expertise in a particular field of general medicine." *See also, Webster's New World College Dictionary* (4th ed, 2002)("specialize" means "to make special, specific, or particular; specify ... to direct toward or concentrate on a specific end ... to make a special study of something or work only in one part or branch of a subject, profession, *etc* ..."); *Oxford English Reference Dictionary* (Rev. 2d ed, 2002)("specialist" means "... a person who specially or exclusively studies a subject or a particular branch of a subject ..."); *Merriam-Webster's Collegiate Dictionary* (11th ed 2004) ("specialize" means "to apply or direct to a specific end or use ... to concentrate one's efforts in a special activity, field, or practice ..."); *Webster's*

Universal College Dictionary (2001) ("specialist" includes " ... a medical practitioner who deals only with a particular class of diseases, conditions, patients, etc. ... ")

These well-accepted definitions of "specialty," "specialist," and "specialize" are broad enough to encompass the more particularized training, qualifications, and practice areas which, although sometimes referred to as subspecialties, are in fact only narrower specialties. The statute does not expressly limit its scope to *primary* or *general* specialties or expressly exclude *narrower or more focused* specialties. This Court would have to read words into the statute to impose such a restriction, but doing so would defeat the express purpose of the statute. If, for example, "specialty" is to be given no greater meaning in this context than "pediatrics," a pediatric nephrologist would be qualified to testify against a pediatric oncologist, and a pediatric rheumatologist could testify against a pediatric neonatologist, solely because they share an umbrella board certification in pediatrics. However, such an interpretation would fail to give any meaning to the statute's use of the word "same" because no one could veritably insist that one pediatric specialty is the "same' as another, e.g., pediatric oncology and pediatric rheumatology or endocrinology, even though each practitioner has first been certified by the American Board of Pediatrics.

Giving "specialty" a meaning that includes sub-specialties is consistent with other legislative uses of the word. Section 16105(3) of Part 161 of the Public Health Code, which contains "General Provisions," defines a "health profession specialty field" as "an area of practice established under this article which is within the scope of activities, functions, and duties of a licensed health profession and which requires advanced education and training beyond that required for initial licensure." MCL 333.16105(3). Nothing in this definition of "specialty field"

distinguishes between specialties or sub-specialties or excludes sub-specialties from the intended meaning. In fact, sub-specialties fit neatly within the definition.

Part 27 of the Public Health Code pertains to "Michigan Essential Health Provider Recruitment Strategy." Sections 2705 and 2707 establish the terms upon which the health department may provide minority grants and tuition loan repayments for health professionals who agree to engage in the full-time practice in a health resource shortage area. MCL 333.2705, MCL 333.2707. Section 2711 requires the department to recruit "physicians qualified or students training to become qualified" in designated physician "specialty" areas and requires that the physicians be "board certified, or eligible for board certification" in those areas. MCL 333.2711. Section 2701(a) defines "board certified" to mean "certified to practice in a particular medical specialty by a national board recognized by the American board of medical specialties or the American osteopathic association [sic]." MCL 333.2701(a). Although not expressly stated, the context implicitly encompasses sub-specialties because the American Board of Medical Specialties ("ABMS") and the American Osteopathic Association ("AOA") recognize boards that "certify to practice in a particular medical specialty" that might otherwise be considered a sub-specialty, such as cardiology, nephrology, and gastroenterology.

In related sections of Part 27, the department is authorized to develop criteria regarding the "[a]verage time the resident population must travel to obtain physician services from physicians in a designated physician specialty area" and to make recommendations concerning "physician specialty areas or other health professions for inclusion in the Michigan essential health provider recruitment strategy." MCL 333.2717(1)(i) and MCL 333.2723(b). Only by artificial distinction could one logically conclude that these statutes do not allow

recommendations and travel time criteria for sub-specialists, whose services may be as critically needed (and in even shorter supply) than more generalized specialists.

Section 5815(a) of Part 58 of the Public Health Code applicable to "Crippled Children," requires the health department to establish and administer a program of services for crippled children and to "prescribe requirements for the approval of facilities and treatment centers, *medical and surgical specialists*, and other providers ..." MCL 333.5815(a) (emphasis added). Similarly, Section 5826 allows the department to approve *medical and surgical specialists* to render services. MCL 333.5826 (emphasis added). Because surgery is itself a specialty, "surgical specialists" can only mean sub-specialists within the practice of surgery such as pediatric surgeons, orthopedic surgeons, neurosurgeons, and cardiac surgeons. Further, it would be illogical to allow the department to prescribe requirements for "medical and surgical specialists" – such as pediatricians and general surgeons - but to have no requirements for sub-specialists, such as orthopedic surgeons or neurosurgeons.

Section 2617 of Part 26 (Data, Information, and Research) of the Public Health Code requires that a comprehensive health information system include statewide statistics relating to a variety of subjects including "[t]he utilization of health care, which may include the utilization of ambulatory health services by *specialties* and types of practices of the health professionals providing the services ..." MCL 333.2617(f) (emphasis added). Only a contorted interpretation of the word "specialty" would exclude from the survey the utilization statistics of sub-specialty fields like cardiology, nephrology, oncology, gastroenterology and the like.

Sub-specialties are also implicit in the Legislature's use of the word "specialist" in statutes outside the Public and Mental Health Codes. For example, MCL 791.244, which sets forth procedures for gubernatorial reprieves, commutation of sentences and pardons, provides

that the office of health care shall evaluate the condition of a prisoner in all cases where a commutation application is based on physical or mental incapacity and if the office of health care confirms that a physical or mental incapacity exists, it "shall appoint a *specialist in the appropriate field of medicine* ... to evaluate the condition of the prisoner." MCL 791.244(2)(d) (emphasis added). In this context, "the appropriate field of medicine" could well be cardiology if the prisoner suffers from heart disease, oncology if the physical incapacitation is cancer, nephrology if the prisoner suffers from kidney disease, or endocrinology if diabetes is the disabling cause. Nothing in the statute limits the specialist to be appointed under such circumstances to the umbrella specialties.

The same is true of uses of the word "specialist" and "specializes" in the Revised Judicature Act, of which the expert witness statute is a part. Enacted in 1986 along with the earlier version of the expert witness qualification statute, MCL 600.4905(1) requires that the health care provider members of medical malpractice mediation panels "specialize in the same or a related, relevant area of health care as the defendant" if the defendant is a "specialist." Similarly, Section 401d of the Nonprofit Health Care Corporation Reform Act, MCL 550.1401d, provides reimbursement for services performed by a physician's assistant who works for a physician or facility that *specializes* in a particular area of medicine if the "physician that *specializes* in that area is physically present on the premises when the physician's assistant's services are performed." MCL 550.1401d(1)(a) (emphasis added). It would be illogical to exclude sub-specialty practice areas from the definition of "specializes" or "specialist" in either of these contexts. For example, it would be every bit as urgent – if not more so – to insure that a "nephrologist" is present when a physician's assistant performs nephrology services as it is to ..sure that an internal medicine specialist is present when the PA is performing services in the

field of internal medicine. Similarly, the policy reasons that suggest the need for health care provider members of medical malpractice mediation panels to specialize in the same or a related, relevant field as the defendant, apply equally to defendants who are sub-specialists.

These statutes are compelling. Only a contorted, illogical interpretation would exclude sub-specialists from the meaning of "specialize" or "specialty" in any of these provisions – why then would the terms warrant a different definition in the expert witness context? When the same word or phrase is used in different parts of a statute, it is presumed to have the same meaning throughout. *See Phipps v Campbell, Wyant & Cannon Foundry*, 39 Mich App 199, 216; 197 NW2d 297 (1972). Although the above provisions are not part of the same statute, the same rule should apply. "Specialize" cannot mean one thing in some legislative enactments and another thing in others.[20]

Thus, within the meaning of MCL 600.2169(1)(a) and (1)(b)(i), "specialize" and "that specialty" must include sub-specialties. A general pediatrician who treats developmentally disabled children and specializes in genetics is not qualified, under the statute, to testify against a defendant who specializes – and was specializing at the time of the alleged malpractice - in pediatric critical care medicine and perinatology-neonatology. As the Court of Appeals explained in the present case:

> Because the basis of the action is grounded in pediatric intensive care, plaintiffs were mandated by § 2169(1)(a) to present an expert who possessed that specialization. Dr. Casamassima's clinical practice during the year immediately preceding the instant injury, §2169(1)(b), did not involve pediatric critical care medicine. Given that Dr. Casamassima acknowledged that he was unaware of the precise standard of care for the treatment of critically ill infants, it is clear that plaintiffs were required to present an expert witness who was.

[20] The fact that MCL 333.17001 uses the term "subspecialty" as well as "specialty" does not negate the fact that subspecialty is subsumed within the meaning of specialty.

Woodard v Custer, 2003 Mich App LEXIS 2647 *12 (2003), *rev'd in part* 473 Mich 1; 701 NW2d 133 (2005). *See also, Giusti v Mt. Clemens General Hospital,* 2003 Mich App LEXIS 3053 (2003) (Court of Appeals held that an expert whose testimony clearly and unequivocally demonstrated that he did not devote a majority of his professional time to the active clinical practice of emergency medicine for ten years preceding the date of the occurrence that gave rise to the action, was not qualified under the statute). The Court of Appeals' holding was correct and should be affirmed.

C. "Board Certified" Includes Certificates of Added Qualification.

Words derive meaning from the "context or setting" in which they are used. *Macomb County Prosecuting Attorney v Murphy,* 464 Mich 149, 159; 627 NW2d 247 (2001). Thus, to interpret the meaning of "that specialty" in the second sentence of MCL 600.2169(1)(a), this Court must consider "its placement and purpose in the statutory scheme." *Sun Valley Foods Co v Ward,* 460 Mich 230, 237; 596 NW2d 119 (1999).

The second sentence of MCL 600.2169(1)(a) follows the requirement that the expert specialize in the same specialty as the defendant. Thus, the board certification requirement in the second sentence of Section 2169(1)(a) will not be triggered unless the expert and the defendant specialize in the same field. If matching specialties have been established, the added board certification requirement - the second sentence requirement - must be satisfied. This sentence provides:

> However, if the party against whom or on whose behalf the testimony is offered is a specialist who is board certified, the expert witness must be a specialist who is board certified in that specialty.

This added requirement can only mean that the expert must possess the same board certifications as the defendant inasmuch as the defendant and expert are already required to

practice the same specialty.[21] It would be illogical to ignore certificates of added qualification when assessing compliance with the matching board certification requirement. These certificates are in fact "certifications" issued by one of the 24 ABMS boards or 18 AOA boards. They demonstrate proficiency in a focused area of specialty practice that is not possessed by other practitioners in the specialty. *See American Board of Medical Specialties Policy Statements and Resolutions* at 9 ("The purpose of subspecialty certificates is to establish standards of preparation to be required of those individuals who wish to provide care to the public in a subspecialty area that the ABMS has determined is of sufficient importance to be so designated ... It is the policy of the ABMS that recognition of subspecialty certification should be primarily for individuals who are devoting a major portion of their time and efforts to that restricted special field. Subspecialty certification should be granted only after education and training or experience *in addition to that required for general certification in the discipline.*") (emphasis added). Requiring that added qualification certifications be included in the matching credentials requirement serves to further the purpose of the statute.

As discussed above, the Public Health Code defines "board certified" to mean "certified to practice in a particular medical specialty by a national board recognized by the American board of medical specialties or the American osteopathic association [sic]." MCL 333.2701(a). Again, because the ABMS and the AOA recognize boards that certify physicians in "particular medical specialties" that might otherwise be considered sub-specialties, those further certifications are "board certifications" within the meaning of the statute.

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[21] Thus, even if "that specialty" referred to the specialty in which the expert witness specialized, by virtue of the first sentence-matching specialties requirement, the result would be the same.

A similarly broad definition of "board certified" is contained within the Commissioned Corps Personnel Manual ("CCPM") of the U.S. Department of Health and Human Services. In an instruction regulating special pay for commissioned officers of the Public Health Service, the Department gives a definition of "board certified medical officer":

> Board Certified (Medical Officers). A medical officer who is currently credentialed in a medical specialty by a examining board approved by the American Board of Medical Specialties of the American Medical Association (AMA) or the American Osteopathic Association (AOA).

CCPM 22.2 Instruction 1(c)(3), available at http://dcp.psc.gov/PDF_docs/221.pdf. *See also, In the Matter of Dominc J. Belmonte*, 813 NE2d 621, 624; 780 NYS2d 541 (Ct App NY 2004)("the most natural interpretation is that 'board certified' refers to certification by a medical specialty board and we read the statute accordingly"); *Nunez v Temple Professional Associates*, 2005 US District LEXIS 2776 at *19 (2004)("Board certification is a process by which a physician becomes credentialed as a specialist in his or her chosen field. Each medical specialty has its own Board that sets requirements for becoming certified; the American Board of Medical specialties oversees these Member Boards in their awards of certification.").

As described above, the American Board of Pediatrics provides certifications in a number of specialty fields within the general umbrella of pediatrics including pediatric critical care medicine, neonatal/perinatal medicine, adolescent medicine, developmental-behavioral pediatrics, pediatric emergency medicine, pediatric endocrinology, pediatric gastroenterology, pediatric hematology-oncology, pediatric infectious diseases, pediatric nephrology, pediatric pulmonology and pediatric rheumatology.[22] Further, the American Board of Pediatrics does not distinguish between board certifications and certificates of added qualification when providing

[22] https://www.abp.org/status/numips.htm

information regarding a physician's certification status. A search for certification information regarding Dr. Custer indicates the following:[23]

Certification Results for
Joseph Custer
Director of Pediatric Critical Care
Ann Arbor, MI 48109

Area of Certification	Exam Type	Requirements Completed	Cert/Recert Begins	Cert Expires
Neonatal/ Perinatal Medicine	Certification	1979	1979	No Expiration
General Pediatrics	Certification	1977	1977	No Expiration

A similar request for information regarding Dr. Casamassima states:[24]

Certification Results for
Anthony Casamassima
Address Unknown
White Plains, NY XXXXX

Area of Certification	Exam Type	Requirements Completed	Cert/Recert Begins	Cert Expires
General Pediatrics	Certification	1982	1982	No Expiration

There is no basis for distinguishing between general board certifications and certifications of added qualification when applying the requirement of matching board certifications. Certificates of added qualification are issued by a recognized ABMS board and certify that the recipient has additional education, training and experience in a particular field.

Thus, general board certifications and certificates of added qualification are equal representations of the training and qualifications of the holder. If a primary board certification matches but the more particularized board certifications do not, the requirement of the statute has

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[23] http://www.abp.org/Verification/CertsSearch?abpid=00037123

[24] http://www.abp.org/Verification /CertsSearch?abpid=00042088

not been fulfilled. In this case, it is not enough that Dr. Custer and Dr. Casamassima are each board certified by the American Board of Pediatrics. Dr. Custer possesses additional board certifications in pediatric critical care medicine and perinatology/neonatoloy that Dr. Casamassima does not possess. This end-line mismatch is determinative. The expert is not certified in the same specialties as the Defendant. Differing certifications are indicative of significant differences between the Defendant's training, qualification and experience, and the expert's. It is these differences that the amended statute was designed to eliminate. Under the plain language of the statute, the matching certification requirement has not been met in this case.

D. All Board Certifications and Certificates of Added Qualifications Must Match.

MCL 600.2169 does not permit a Court to decide which of a defendant's board certifications must be matched and which need not be. There is no support in the statute for the result reached by the Court of Appeals in *Tate v Receiving Hospital. Tate v Receiving Hospital,* 249 Mich App 212; 642 NW2d 346 (2002), where an expert witness who specialized and was board certified in internal medicine was permitted to testify against a defendant who was board certified in internal medicine *and several other specialties.* The plaintiff in *Tate* argued that this was appropriate because the medical malpractice occurred during the practice of internal medicine and not during the practice of the other specialties. The *Tate* Court agreed, stating that the "use of the phrase 'at the time of the occurrence that is the basis for the action' clearly indicates that an expert's specialty is limited to the actual malpractice." *Tate,* 249 Mich App at 218. The *Tate* court further noted the statute's use of the word "specialty" rather than "specialties" implies "that the specialty requirement is tied to the occurrence of the alleged malpractice and not unrelated specialties that a defendant physician may hold." *Id.* The *Tate*

court concluded that MCL 600.2169 could not be interpreted to require "an exact match of every board certification held by a defendant physician" and that a perfect match requirement would make "it virtually impossible to bring a medical malpractice case." *Id.* at 219. The *Tate* court thus held that "where a defendant physician has several board certifications and the alleged malpractice only involves one of these specialties, § 2169 requires an expert witness to possess the same specialty as that engaged in by the defendant physician during the course of the alleged malpractice." *Id.* at 220.

The decision in *Tate* is wrong. Nothing in the phraseology of the second sentence of (1)(a) limits the matching board certification requirement to the specialty out of which the claim for malpractice arose. The "at the time of the occurrence that is the basis for the action" language in the first sentence is simply a temporal requirement. It specifies that the specialty of the defendant at the time of the occurrence and the specialty of the expert at the time of the occurrence must be the same. It does not say that the matching specialties requirement relates to the specialty involved in the claim, much less limit the matching requirement to the involved specialty area. *See e.g., Kyser v Hillsdale Community Health Center,* 2003 Mich App LEXIS 1757 at * 3 (2003) ("The fact that [defendant, who was board certified in internal medicine] may have been acting as an emergency room doctor is irrelevant. The statute provides that an expert must specialize 'in the same specialty' as the defendant doctor, not that he must specialize in the area of medicine being practiced by the defendant doctor at the time the cause of action arose.").

Equally specious is the reliance of the *Tate* court on the use of the singular "specialty." The court cited this observation in support of its holding that the matching requirement only applied to the specialty involved in the claim. However, the court's narrow interpretation of the "specialty" reference ignores a statutory rule of construction which provides that "[e]very word

importing the singular number only may extend to and embrace the plural number, and every word importing the plural number may be applied and limited to the singular number." MCL 8.3b. *See also, Crowley-Milner & Co v Macomb Circuit Judge,* 239 Mich 605; 215 NW 29 (1927)(the word "judge" as used in statute regarding the disqualification of judges, should be read "judges.")

CONCLUSION AND RELIEF REQUESTED

In the serious business of medical malpractice litigation the Legislature has directed, as a matter of substantive law, that the certifications and specialties of the defendant and the expert be the "same" and that the expert devote a majority of his professional time to active clinical practice or instruction in that specialty. The requirements of the statute are not satisfied in this case. The specialty differences between the defendant and his opposing expert are well-documented. As such, the plain language of the statute requires the expert's exclusion. Amicus Curiae Michigan State Medical Society therefore joins Defendant-Appellee's request to affirm the Court of Appeals' decision.

KERR, RUSSELL AND WEBER, PLC

By: Joanne Geha Swanson

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Dated: October 11, 2005

STATE OF MICHIGAN
IN THE SUPREME COURT

JOHANNA WOODARD, Individually and as Next Friend of AUSTIN D. WOODARD, a Minor, and STEVEN WOODARD,

Plaintiffs-Appellees/
Cross-Appellants

vs.

JOSEPH R. CUSTER, M.D.,

Defendant-Appellant/
Cross-Appellee

and

MICHAEL K. LIPSCOMB, M.D., MICHELLE M. NYPAVER, M.D., AND MONA M. RISKALLA, M.D.,

Defendants

Supreme Court No. 124994
Court of Appeals No. 239868
Washtenaw County Circuit Court
Case No. 99-005364-NH

JOHANNA WOODARD, Individually and as Next Friend of AUSTIN D. WOODARD, a Minor, and STEVEN WOODARD,

Plaintiffs-Appellees/
Cross-Appellants

vs.

UNIVERSITY OF MICHIGAN MEDICAL CENTER,

Defendant-Appellant/
Cross-Appellee

Supreme Court No. 124995
Court of Appeals No. 239869
Court of Claims
Case No. 99-017432-CM

CERTIFICATE OF SERVICE

I hereby certify that a true and accurate copy of the Motion of MSM for Leave to File Amicus Curiae Brief in Support of Defendant/Cross-Appellee and the Amicus Curiae Brief of Michigan State Medical Society was served this 11th day October, 2005, via First Class Mail upon the following:

Craig L. Nemier, Esq.
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by placing said documents in a well-sealed envelope with first-class postage fully affixed thereon and by placing said envelopes in a U.S. mail depository located in Detroit, Michigan.

Cynthia J. Villeneuve

Subscribed and sworn to before me
this 11th day of October, 2005.

Notary Public, Wayne County, MI
My Commission expires:_____
Acting in Wayne County, MI

GAIL R. SHOWLER
Notary Public, Wayne County, MI
My Commission Expires Feb. 20, 2008
Acting in the County of Wayne

UNPUBLISHED CASES

LEXSEE 2003 MICH APP LEXIS 3053

GARY E. GIUSTI, Plaintiff-Appellant, and BLUE CROSS & BLUE SHIELD OF MICHIGAN, Intervening Plaintiff, v MT. CLEMENS GENERAL HOSPITAL, Defendant-Appellee, and JAMES LARKIN, D.O., JAY KANER, D.O., and TRI-COUNTY NEUROLOGICAL ASSOCIATES, P.C., Defendants.

No. 241714

COURT OF APPEALS OF MICHIGAN

2003 Mich. App. LEXIS 3053

December 2, 2003, Decided

NOTICE: [*1] THIS IS AN UNPUBLISHED OPINION. IN ACCORDANCE WITH MICHIGAN COURT OF APPEALS RULES, UNPUBLISHED OPINIONS ARE NOT PRECEDENTIALLY BINDING UNDER THE RULES OF STARE DECISIS.

PRIOR HISTORY: Macomb Circuit Court. LC No. 1999-003849-NH.

DISPOSITION: Affirmed.

JUDGES: Before: Schuette, P.J., and Cavanagh and White, JJ. WHITE, J. (concurring in part and dissenting in part).

OPINION: PER CURIAM.

Plaintiff appeals as of right the trial court's grant of summary disposition in this medical malpractice action. We affirm.

On September 14, 1999, plaintiff commenced this action alleging that as a result of negligence, malpractice, and willful and wanton misconduct with regard to the medical treatment he received in 1997 following presentations to the emergency room, during a hospital admission, and during post-hospitalization visits, he suffered severe injuries. The defendants were Mt. Clemens General Hospital (MCGH), an emergency room physician at MCGH, Dr. James Larkin, a neurologist at MCGH, Dr. Jay Kaner, and Tri-County Neurological Associates, P.C. The affidavit of merit was signed by Alexander Mauskop, M.D., a purported expert in neurology. A second affidavit of merit was subsequently filed that was signed by Frank J. Baker, [*2] II, M.D., a purported expert in emergency medicine. On March 7, 2001, Dr. Larkin was dismissed as a defendant by stipulation.

On February 25, 2002, MCGH filed a motion for summary disposition, pursuant to *MCR 2.116(C)(8)* and (C)(10), arguing that (1) it could not be vicariously liable for Dr. Kaner's actions because Dr. Kaner had "a separate and distinct physician-patient relationship with Plaintiff which predated the treatment at MCGH at issue," (2) plaintiff's emergency room expert, Dr. Baker, was not qualified pursuant to *MCL 600.2169* to offer such expert testimony because he did not devote a majority of his professional time to the practice of emergency medicine in 1997 but, instead, worked half-time in emergency medicine, and (3) even if Dr. Baker was qualified to testify, plaintiff failed to establish causation.

On March 1, 2002, Dr. Kaner and Tri-County Neurological Associates moved for summary disposition, pursuant to *MCR 2.116(C)(10)*, arguing that plaintiff failed to establish a breach in the standard of care since his neurology expert, Dr. Mauskop, indicated that "if the facts of the case were consistent with Dr. Kaner's testimony, then no violation [*3] of the standard of care existed."

On March 13, 2002, plaintiff responded to MCGH's motion for summary disposition and stipulated that MCGH could not be held vicariously liable for the actions of Dr. Kaner. Plaintiff argued, however, that (1) Dr. Baker was qualified as an expert in emergency medicine as evidenced by his testimony that, in 1997, he worked eight to ten shifts a month when full-time was considered fourteen shifts a month and, further, by his affidavit attached for consideration which indicated that in the immediately preceding year he devoted a majority of his professional time to the active clinical practice of emergency medicine, (2) *MCL 600.2169* did not apply to the action because, at the time the lawsuit was filed, the statute was adjudicated unconstitutional, (3) plaintiff's causation expert, Dr. Mauskop, testified that an occluded carotid artery could have been detected at his initial presentation to MCGH with proper testing, and (4) Dr. Larkin's and

Dr. Kaner's testimony could be used to establish a breach in the standard of care and proximate cause.

On March 29, 2002, a stipulation and order dismissing, with prejudice, Dr. Kaner and [*4] Tri-County Neurological Associates was entered by the court. On May 16, 2002, the trial court issued its opinion and order granting MCGH's motion for summary disposition pursuant to *MCR 2.116(C)(8)* and (C)(10). The trial court held that (1) *MCL 600.2169* applied to the case, (2) Dr. Baker was not qualified under *MCL 600.2169* because he admitted in his deposition that he considered himself to work only half-time and, thus, did not devote a majority of his professional time to the practice of emergency room medicine, (3) Dr. Mauskop testified that he would not offer testimony as to the standard of care relative to emergency room physicians or other physicians involved in the original hospitalizations and, thus, was neither qualified nor prepared to testify as to emergency room care rendered to plaintiff, and (4) plaintiff's reliance on Dr. Larkin and Dr. Kaner as experts was unsupported because the record did not reflect that either physician was qualified under *MCL 600.2169* or that either could establish the standard of care or breach of such standard of care. Accordingly, the case was dismissed. This appeal [*5] followed.

Plaintiff argues that the trial court erred in prohibiting Dr. Baker from testifying in this case because he was qualified under *MCL 600.2169* to render expert testimony. We disagree. The qualification of a witness as an expert, and the admissibility of such testimony as evidence, are in the trial court's discretion and will not be reversed on appeal absent an abuse of that discretion. *Mulholland v DEC Int'l Corp, 432 Mich. 395, 402; 443 N.W.2d 340 (1989).*

To establish a prima facie case of professional negligence in a medical malpractice action the plaintiff must prove the applicable standard of care, breach of that standard, and an injury caused by that breach. See *Weymers v Khera, 454 Mich. 639, 655; 563 N.W.2d 647 (1997).* Expert testimony is mandatory, with few exceptions. *Locke v Pachtman, 446 Mich. 216, 223224, 230; 521 N.W.2d 786 (1994); Carlton v St John Hosp, 182 Mich. App. 166, 171; 451 N.W.2d 543 (1989). MCL 600.2169* imposes requirements regarding the qualifications of expert witnesses [*6] who would render such testimony, and provides:

> (1) In an action alleging medical malpractice, a person shall not give expert testimony on the appropriate standard of practice or care unless the person is licensed as a health professional in this state or another state and meets the following criteria:
>
> * * *
>
> (b) Subject to subdivision (c), during the year immediately proceeding the date of the occurrence that is the basis for the claim or action, devoted a majority of his or her professional time to either or both of the following:
>
> (i) The active clinical practice of the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, if that party is a specialist, the active clinical practice of that specialty.
>
> (ii) The instruction of students in an accredited health professional school or accredited residency or clinical research program in the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, if that party is a specialist, an accredited health professional school or accredited residency or clinical research program in the same specialty. [*7]

In this case, the trial court concluded that Dr. Baker did not devote a majority of his professional time to the active clinical practice of emergency medicine or the instruction of students in emergency medicine. We agree with the trial court.

Dr. Baker testified, in pertinent part, as follows:

> *Q.* And in 1997, which was the time frame in question in this particular case, were you working full-time as an ER physician?
>
> *A.* In 1997, I was basically half-time in emergency medicine. I was working at MacNeal Hospital, doing eight to ten shifts a month. The full-timers were doing about 14.
>
> *Q.* When did you - what was the first year you started becoming half-time in ER? *A.* Well, in terms of half-time clinical, it was when I left the University of Chicago. I decided I wasn't going to work any more hundred hour weeks. *Q.* I don't blame you. So after 1987, at least from a clinical standpoint, after leaving the University of Chicago, you have been half-time in ER medicine, correct, from a clinical standpoint?

A. Yes.

Dr. Baker's testimony was clear and unequivocal—he did not devote a majority of his professional [*8] time to the active clinical practice of emergency medicine for about the ten years preceding the date of the occurrence that gave rise to this action. Although he testified that he averaged 20 to 24 hours a week, he also testified that he considered himself to be half-time clinical because he spent one day a week reviewing cases as an expert witness, "another day a week doing medical education-related things, mostly related to my own CME" and he spent "a significant amount of time working on overseas programs, mostly in Russia and the former Soviet Union." In our opinion, Dr. Baker's own interpretation as to his employment status, i.e., that he did not devote a *majority* of his professional time to active clinical practice, is the most reliable and must prevail over any nullifying interpretation, including his submission of a later, contrary affidavit. See *Dykes v William Beaumont Hosp, 246 Mich. App. 471, 479-480; 633 N.W.2d 440 (2001)*. And, in light of the facts, his interpretation appears accurate. Further, Dr. Baker did not formally instruct students in emergency medicine. Practicing medicine in a teaching hospital does not fulfill the requirements [*9] of *MCL 600.2169(1)(b)(ii)*. Accordingly, we do not agree with the dissenting opinion that the trial court abused its discretion in disqualifying Dr. Baker as an expert witness under *MCL 600.2169*. Considering the facts on which the trial court acted, we cannot say that its decision was without justification or excuse, *Ellsworth v Hotel Corp of America, 236 Mich. App. 185, 188; 600 N.W.2d 129 (1999)*, or was "so palpably and grossly violative of fact and logic that it evidences perversity of will, a defiance of judgment, or the exercise of passion or bias," *Barrett v Kirtland Community College, 245 Mich. App. 306, 325; 628 N.W.2d 63 (2001)*.

Next, plaintiff argues that the trial court abused its discretion in prohibiting Dr. Mauskop from testifying on the issue of causation. We disagree. After the trial court noted that plaintiff's only remaining claims were against MCGH and were related to emergency room visits, it held that Dr. Mauskop, a neurologist, was not qualified under *MCL 600.2169* to offer expert testimony regarding treatment rendered to [*10] plaintiff by emergency room physicians. In his appeal brief, plaintiff does not address this finding, but merely argues that Dr. Mauskop was qualified to testify as to the issue of causation. However, even if Dr. Mauskop was qualified to testify as to the issue of causation, he was not qualified to testify as to the standard of care and breach of the standard of care related to the treatment rendered by emergency room physicians during the emergency room visits. Therefore, this is not a ground on which to reverse the trial court's grant of summary dismissal.

Finally, plaintiff argues that he should be able to elicit the necessary causation testimony from the former defendants, Drs. Larkin and Kaner, to establish his prima facie case. We disagree. As noted by the trial court, the record did not establish that either physician was qualified under *MCL 600.2169* to render such expert testimony. Contrary to plaintiff's argument on appeal that "the qualifications of these doctors to testify as experts cannot be seriously disputed," both physicians could actually devote only half of their professional time to the practice of neurology and emergency room medicine. [*11] Accordingly, plaintiff failed to establish that the requirements of *MCL 600.2169* have been met with regard to either physician.

Further, even if Dr. Larkin was qualified to render expert testimony as to the applicable standard of care related to plaintiff's emergency room visits, his testimony regarding a breach of that standard and causation consisted of, as held by the trial court, "nothing more than conjecture concerning 'inappropriate' behavior hypothetically attributed to an emergency room nurse." And, even if Dr. Kaner was qualified to render causation testimony, he was not qualified to testify as to the standard of care and breach of the standard of care related to the treatment rendered by emergency room physicians during plaintiff's emergency room visits. Therefore, this issue is without merit. In sum, the trial court properly granted summary disposition in MCGH's favor because plaintiff lacked sufficient expert testimony to establish a prima facie case of medical malpractice.

Affirmed.

/s/ Bill Schuette

/s/ Mark J. Cavanagh

CONCURBY: Helene N. White (In Part)

DISSENTBY: Helene N. White (In Part)

DISSENT: WHITE, J. (*concurring in part and dissenting* [*12] *in part*).

I respectfully dissent from the majority's determination that the trial court properly disqualified Dr. Baker as an expert witness. Dr. Baker, who is board-certified in emergency medicine, never testified that he did not spend a majority of his time in ER clinical practice. Dr. Baker testified that in 1997 he spent twenty to twenty-four hours a week in ER clinical practice. He also testified that in 1997 he was doing eight to ten shifts of ER a month,

while the full-timers were doing about fourteen shifts. Clearly, that is more than "half-time," and Dr. Baker's use of that term at his deposition was an approximation, as his testimony makes clear:

> *Q*. During the 1997 period that's the issue—the focus on what the case is here, half of your time was spent in ER clinical. And what were you doing with the rest of your professional time?
>
> *A*. Well, I spent-and, you know, I sort of say half-time, but it was actually more than 20 hours a week because we also worked 12-hour shifts. We worked eights and twelves, so it was on the average of say, 20 to 24 hours a week. But, you know, I considered myself to be half-time clinical. I spend about one day a [*13] week doing this sort of stuff. I spend about another day a week doing medical education related things, mostly related to my own CME. And then at that time, I was spending a significant amount of time working on overseas programs, mostly in Russia and the former Soviet Union.

Thus, I disagree with the majority's assertion that Dr. Baker's testimony was "clear and unequivocal—he only devoted half of his professional time to the active clinical practice of emergency medicine . . . " Dr. Baker's enumeration of how he spent his days, cited by the majority as evidence that he did not devote more than half his time to ER clinical practice, was in response to questioning regarding what else he did with his time, i.e., what he did with his time beyond the more than half-time he devoted to ER clinical practice.

Further, Dr. Baker's affidavit does not contradict his deposition testimony. The affidavit states "I devoted a majority of my professional time to the active clinical practice of emergency medicine in the year immediately preceding the events in question," which is completely in keeping with Dr. Baker's deposition testimony.

I agree with the majority's rejection of plaintiff's [*14] remaining arguments. With respect to Dr. Mauskop, plaintiff failed to show that he actually provided adequate proximate cause testimony. Regarding Drs. Larkin and Kaner, plaintiff failed to show that they in fact would provide testimony on violation of the standard of care or that any violation was a proximate cause of injury.

/s/ Helene N. White

LEXSEE 2003 MICH APP LEXIS 1757

LOREN KYSER, Plaintiff-Appellee, and BLUE CROSS & BLUE SHIELD OF MICHIGAN, Intervening Plaintiff-Appellee, v HILLSDALE COMMUNITY HEALTH CENTER, Defendant-Appellant, and ARNEL LARCIA, M.D., DR. KALPESH PANCHAL and DR. ROSS MILLER, Defendants.

No. 237060

COURT OF APPEALS OF MICHIGAN

2003 Mich. App. LEXIS 1757

July 22, 2003, Decided

NOTICE: [*1] THIS IS AN UNPUBLISHED OPINION. IN ACCORDANCE WITH MICHIGAN COURT OF APPEALS RULES, UNPUBLISHED OPINIONS ARE NOT PRECEDENTIALLY BINDING UNDER THE RULES OF STARE DECISIS.

PRIOR HISTORY: Hillsdale Circuit Court. LC No. 00-000826-NH.

DISPOSITION: Reversed and remanded for further proceedings consistent with this opinion. We do not retain jurisdiction.

JUDGES: Before: Zahra, P.J., and Talbot and Owens, JJ.

OPINION: PER CURIAM.

Defendant Hillsdale appeals by leave granted from a circuit court order denying its motion for summary disposition in this medical malpractice action. We reverse and remand. This appeal is being decided without oral argument pursuant to *MCR 7.214(E)*.

Plaintiff sought to hold defendant liable for the negligence of the individual doctors who treated him. At issue here is defendant's liability for the alleged malpractice of defendant Larcia. Plaintiff filed this action on the last day of the limitations period. The complaint was supported by an affidavit from Gary Harris, a board certified specialist in emergency room medicine. Defendant moved to dismiss on the ground that the affidavit was insufficient under *MCL 600.2912d(1)* and *MCL 600.2169(1)* [*2] because Larcia is board certified in internal medicine. The trial court ruled that because Larcia was working in defendant's emergency room at the time he treated plaintiff, he should be held to the standard of an emergency room physician and, thus, Harris' affidavit was sufficient. The trial court's ruling on a motion for summary disposition is reviewed de novo. *Kefgen v Davidson, 241 Mich. App. 611, 616; 617 N.W.2d 351 (2000)*. Statutory interpretation is a question of law that is also reviewed de novo. *In re MCI Telecom, 460 Mich. 396, 413; 596 N.W.2d 164 (1999)*.

A plaintiff filing a medical malpractice action is required to file "an affidavit of merit signed by a health professional who the plaintiff's attorney reasonably believes meets the requirements for an expert witness under section 2169." *MCL 600.2912d(1)*. Section 2169 requires that if the defendant doctor is a specialist, the expert witness must specialize in the same specialty. If the defendant doctor is a board certified specialist, the expert witness must also be board certified in that specialty. *MCL 600.2169(1)(a)* [*3] . In addition, the expert must devote the majority of his professional time to the practice or teaching of the same health profession or specialty as practiced by the party against whom he testifies. *MCL 600.2169(1)(b)*, (c).

Plaintiff's expert's affidavit of merit is nonconforming. Harris was not board certified in internal medicine and there is nothing in his affidavit to indicate that, at the time plaintiff's cause of action arose, he spent the majority of his professional time practicing or teaching that (or any) specialty. The fact that Larcia may have been acting as an emergency room doctor is irrelevant. The statute provides that an expert must specialize "in the same specialty" as the defendant doctor, not that he must specialize in the area of medicine being practiced by the defendant doctor at the time the cause of action arose. *Decker v Flood, 248 Mich. App. 75, 83-84; 638 N.W.2d 163 (2002)*. Therefore, we reverse the trial court's ruling that the affidavit of merit was sufficient. n1

n1 We decline to rule on the legal effect of our conclusion that the affidavit of merit was insufficient. Instead, that issue should be properly briefed and argued before the trial court.

/s/ Brian K. Zahra

[*4]

/s/ Michael J. Talbot

Reversed and remanded for further proceedings consistent with this opinion. We do not retain jurisdiction.

/s/ Donald S. Owens

LEXSEE 2005 MICH APP LEXIS 119

ROYAL MCQUIRE, Personal Representative of the Estate of MINNIE MCGUIRE, Plaintiff-Appellant, v HARRY J. WASVARY, M.D., Defendant-Appellee, and WILLIAM BEAUMONT HOSPITAL, Defendant.

No. 248309

COURT OF APPEALS OF MICHIGAN

2005 Mich. App. LEXIS 119

January 25, 2005, Decided

NOTICE: [*1] THIS IS AN UNPUBLISHED OPINION. IN ACCORDANCE WITH MICHIGAN COURT OF APPEALS RULES, UNPUBLISHED OPINIONS ARE NOT PRECEDENTIALLY BINDING UNDER THE RULES OF STARE DECISIS.

PRIOR HISTORY: Oakland Circuit Court. LC No. 2002-043598-NH.

DISPOSITION: Affirmed.

JUDGES: Before: Griffin, P.J., and Cavanagh and Fort Hood, JJ.

OPINION: PER CURIAM.

In this medical malpractice action, the defense challenged the qualifications of plaintiff's expert who, in an affidavit filed with the litigation, rendered an opinion regarding the standard of care and any breach. Specifically, defendant Dr. Wasvary asserted that he specialized in colon and rectal surgery at the time of the alleged malpractice. On the contrary, the expert provided by plaintiff was a general surgeon who did not practice in the same specialized area as defendant. Therefore, the defense moved for summary disposition of the complaint. The trial court concluded that the affidavit of merit did not comply with the statutory requirements, and there was no reasonable belief that plaintiff's expert was qualified to render an opinion. We affirm.

On September 6, 2002, plaintiff, the personal representative of the estate of decedent, filed a medical malpractice action, alleging [*2] that the decedent suffered from a bowel obstruction following a colonoscopy in December 1999. Despite the obstruction, plaintiff's decedent was released from the hospital, but was readmitted to the hospital after complaining of abdominal pain. Seven days later, the decedent died. In the complaint, it was alleged that defendant Dr. Wasvary and the general surgery residents of defendant hospital breached the standard of care by discharging her with the presence of the obstruction and failing to properly treat the obstruction, including but not limited to, prescribing the appropriate antibiotics, and failing to diagnose the obstruction. With the complaint, an affidavit of merit was filed by Chester Semel, M.D., indicating that he was a board certified general surgeon at the time of the alleged malpractice and was familiar with the standard of practice of a general surgeon and general surgery resident. The affidavit of merit contained the same alleged breaches of the standard of care delineated in the complaint.

On October 30, 2002, defendant moved for summary disposition. It was alleged that the affidavit filed by plaintiff was defective because Dr. Semel did not practice in the same [*3] specialty as defendant Dr. Wasvary. Furthermore, defendant asserted that he was a fellowship-trained colon and rectal surgeon. However, Dr. Semel was not a specialist in colon and rectal surgery and could only attest to the standard of care for general surgery. Therefore, defendant concluded that plaintiff had failed to comply with the statutory affidavit of merit requirement found in *MCL 600.2912d*, and dismissal was the appropriate remedy for the filing of a defective affidavit of merit.

Plaintiff opposed the motion for summary disposition, asserting that general surgery was a recognized specialty within the field of medicine, and defendant was a board certified general surgeon. n1 Therefore, plaintiff alleged that Dr. Semel, as a board certified general surgeon, was qualified to render an opinion regarding defendant's breach of the standard of care. Additionally, plaintiff alleged that defendant was not board certified in anything other than general surgery at the time of treatment. The trial court concluded that the statutory requirements were not satisfied when plaintiff's expert was a general surgeon whereas defendant was a colorectal surgeon. Additionally, [*4] the trial court concluded that plaintiff could not have

a reasonable belief that Dr. Semel was qualified to render an opinion when plaintiff's counsel had utilized Dr. Semel repeatedly in the past, and therefore, was aware of his qualifications and his expertise.

> n1 Although plaintiff's brief in opposition to the motion for summary disposition is not contained within the lower court file, plaintiff's position can be determined from the surreply brief and the brief on appeal.

Plaintiff asserts that the trial court erred in granting defendant's motion for summary disposition. We disagree. Issues of statutory construction present questions of law that are reviewed de novo. *Cruz v State Farm Mut Auto Ins Co, 466 Mich. 588, 594; 648 N.W.2d 591 (2002).* The goal of statutory construction is to discern and give effect to the intent of the Legislature by examining the most reliable evidence of its intent, the words of the statute. *Neal v Wilkes, 470 Mich. 661, 665; 685 N.W.2d 648 (2004).* [*5] If the statutory language is unambiguous, appellate courts presume that the Legislature intended the plainly expressed meaning and further judicial construction is neither permitted nor required. *DiBenedetto v West Shore Hosp, 461 Mich. 394, 402; 605 N.W.2d 300 (2000).*

Additionally, the rules addressing the propriety of summary disposition are also at issue in this appeal. We review summary disposition decisions de novo. *In re Capuzzi Estate, 470 Mich. 399, 402; 684 N.W.2d 677 (2004).* The moving party has the initial burden to support its claim to summary disposition by affidavits, depositions, admissions, or other documentary evidence. *Quinto v Cross & Peters Co, 451 Mich. 358, 362; 547 N.W.2d 314 (1996).* The burden then shifts to the nonmoving party to demonstrate a genuine issue of disputed fact exists for trial. *Id.* To meet this burden, the nonmoving party must present documentary evidence establishing the existence of a material fact, and the motion is properly granted if this burden is not satisfied. *Id.* Affidavits, depositions, and documentary evidence offered in support of and [*6] in opposition to a dispositive motion shall be considered only to the extent that the content or substance would be admissible as evidence. *Maiden v Rozwood, 461 Mich. 109, 118; 597 N.W.2d 817 (1999).*

MCL 600.2912d(1) provides, in pertinent part:

> Subject to subsection (2), n2 the plaintiff in an action alleging medical malpractice or, if the plaintiff is represented by an attorney, the plaintiff's attorney shall file with the complaint an affidavit of merit signed by a health professional who the plaintiff's attorney reasonably believes meets the requirements for an expert witness under [*MCL 600.2169*].

> n2 Subsection (2) of the statute addresses a motion for an extension of time to file the affidavit of merit where good cause is shown and is not at issue on appeal.

MCL 600.2169 addresses the qualifications of an expert witness in a medical malpractice action and provides, in relevant part: [*7]

> (1) In an action alleging medical malpractice, a person shall not give expert testimony on the appropriate standard of practice or care unless the person is licensed as a health professional in this state or another state and meets the following criteria:
>
> (a) If the party against whom or on whose behalf the testimony is offered is a specialist, specializes at the time of the occurrence that is the basis for the action in the same specialty as the party against whom or on whose behalf the testimony is offered. However, if the party against whom or on whose behalf the testimony is offered is a specialist who is board certified, the expert witness must be a specialist who is board certified in that specialty.

In *Halloran v Bhan, 470 Mich. 572, 575; 683 N.W.2d 129 (2004),* the defendant physician treated the plaintiff's decedent. The defendant was board-certified in internal medicine, but also held a certificate of added qualification in critical care medicine. Both certifications were obtained from the American Board of Internal Medicine (ABIM). The parties did not dispute that the certificate of added qualification was not governed by the [*8] board certification requirements of the medical malpractice statute. *Id.*

The plaintiff presented an expert who was not board-certified in internal medicine. Rather, the plaintiff presented an expert who was board certified in anesthesiology by the American Board of Anesthesiology (ABA). However, the plaintiff's expert also received a certificate of added qualification in critical care medicine from the ABA. The plaintiff's expert was not board certified in internal medicine nor did he have the applicable training that would make him eligible for internal medicine certification. Because the board certifications did not match, the defendant physician moved to strike the plaintiff's expert, and the circuit court agreed. The Court of Appeals reversed, concluding that the expert fell within the statutory requirements where the subspecialty of critical care

was shared by both physicians. *Id.* at 575-576 .

The Supreme Court reversed the holding of the Court of Appeals, stating:

> We must now determine whether *MCL 600.2169(1)(a)* requires that an expert witness share the same board certification as the party against whom or on whose behalf the testimony [*9] is offered. We hold that it does.
>
> The Court of Appeals majority held that it is sufficient under the statute if the expert witness and the defendant doctor share only the same subspecialty, but not the same board certification. We disagree because this argument runs contrary to the plain language of the statute.
>
> This interpretation is supported by the use of the word "however" to begin the second sentence. Undefined statutory terms must be given their plain and ordinary meanings, and it is proper to consult a dictionary for definitions. *Donajkowski v Alpena Power Co, 460 Mich. 243, 248-249; 596 N.W.2d 574 (1999); Koontz v Ameritech Services, Inc, 466 Mich. 304, 312; 645 N.W.2d 34 (2002). Random House Webster's College Dictionary* (2d ed) defines "however" as "in spite of that" and "on the other hand." Applying this definition to the statutory language compels the conclusion that the second sentence imposes an *additional* requirement for expert witness testimony, not an optional one. In other words, "in spite of" the specialty requirement in the first sentence, the witness must also share the same [*10] board certification as the party against whom or on whose behalf the testimony is offered.
>
> There is no exception to the requirements of the statute and neither the Court of Appeals nor this Court has any authority to impose one. As we have invariably stated, the argument that enforcing the Legislature's plain language will lead to unwise policy implications is for the Legislature to review and decide, not this Court. See *Jones v Dep't of Corrections, 468 Mich. 646, 655; 664 N.W.2d 717 (2003).*
>
> It is not disputed that defendant Bhan is board certified in internal medicine, but proposed expert witness Gallagher is not. *MCL 600.2169(1)(a)* requires that the expert witness "must be" a specialist who is board certified in the specialty in which the defendant physician is also board certified. Because the proposed witness in this case is not board certified in the same specialty as Bhan, *MCL 600.2169(1)(a)* prohibits him from testifying regarding the standard of care. [*Id.* at 577-579 (footnotes omitted).]

In the present case, defendant filed an affidavit delineating his education [*11] and experience. Defendant graduated from Wayne State University School of Medicine in 1992, and followed his graduation with a residency in general surgery in 1998, and a fellowship in colon and rectal surgery in 1998-1999. In December 1999, defendant exclusively practiced in the area of colon and rectal surgery, an area he categorized as a distinct sub-specialty of general surgery. At the time of the alleged malpractice, defendant was board *eligible* for certification by the American Board of Colon and Rectal Surgeons and had since obtained his board certification in this specialty. Defendant opined that surgeons who wished to practice in the area of colon and rectal surgery were "typically" required to be specialists trained in the area of colon and rectal surgery. Defendant reviewed the affidavit and qualifications presented by plaintiff's expert. Based on this evaluation, Dr. Semel was not trained in the area of colon or rectal surgery and was not a member of the American Board of Colon and Rectal Surgeons.

Plaintiff did not file an affidavit from Dr. Semel to counter the attestations by defendant in his affidavit. Rather, the only affidavit filed by Dr. Semel was the affidavit [*12] of merit filed with the complaint. This affidavit merely concluded that Dr. Semel was a board certified general surgeon in 1999, and was familiar with the standard of practice for a general surgeon. The affidavit did not delineate whether Dr. Semel had any experience in the area of colon and rectal surgery.

Plaintiff alleges that because both surgeons were board certified in general surgery at the time of the alleged malpractice, the requirements of *MCL 600.2169* are satisfied. We disagree. Again, the key portion of the statute at issue provides:

> (a) If the party against whom or on whose behalf the testimony is offered is a specialist, specializes at the time of the occurrence that is the basis for the action in the same specialty as the party against whom or on whose behalf the testimony is offered. However, if the party against whom or on whose behalf the testimony is offered is a specialist who is board certified, the expert witness must

> be a specialist who is board certified in that specialty.

As stated by the *Halloran* Court, *MCL 600.2169(1)(a)* delineates *two* requirements for qualification of an expert [*13] witness in a medical malpractice case. With regard to the first requirement, the physicians are compared to determine if the physician is a specialist in a particular area. Where the subject of the litigation surrounds the actions of a specialist, that testimony must be countered with the testimony of an individual in the same specialty. *MCL 600.2169(1)(a)*; *Halloran supra* at 578-579. Then, if it is determined that the testimony is offered against a board certified specialist, n3 the testimony offered by a witness must share the same board certification. *Id.*

> n3 We note that this additional requirement is premised upon a contingency. It is invoked *if* a board certified specialist is involved. See e.g., *ISB Sales Co v Dave's Cakes, 258 Mich. App. 520, 529; 672 N.W.2d 181 (2003).*

Here, plaintiff's expert Dr. Semel has merely addressed the fact that both surgeons were board certified general surgeons at the time of the alleged malpractice. Plaintiff [*14] has failed to acknowledge the first requirement of the statute wherein it addresses whether testimony is offered against a specialist. Here, defendant has attested that he was a specialist in the area of colon and rectal surgery, regardless of the status of his board certification at the time of the alleged malpractice. Plaintiff failed to counter this documentary evidence with an affidavit from a specialist in colon and rectal surgery. *Halloran, supra; Maiden, supra.* Plaintiff failed to present any documentation to counter the contention that colon and rectal surgery was a specialty area of general surgery and failed to delineate the qualifications and experience of Dr. Semel in this area. n4 Accordingly, the trial court properly concluded that plaintiff failed to satisfy the requirements of *MCL 600.2169(1)(a). Halloran, supra.*

> n4 We note that plaintiff cites *Watts v Canady, 253 Mich. App. 468; 655 N.W.2d 784 (2002),* for the proposition that there are distinctions between specialist and subspecialists, and that defendant's colon and rectal surgery constitutes a subspecialty of general surgery. However, the *Watts* Court did not reach the issue of whether a subspecialty was encompassed within a specialty for purposes of *MCL 600.2169.* Rather, the *Watts* Court merely held that the plaintiff's attorney had a reasonable belief that the expert was qualified. *Id.* at 471-472. Moreover, we note that *MCL 600.2169* does not define or distinguish between specialist and subspecialists. However, the dictionary defines "specialist" as "a person devoted to one subject or to one particular branch of a subject or pursuit." *Random House Webster's College Dictionary* (2d ed), p 1260. Applying this definition to the statutory language, *Halloran, supra,* reveals that there is no such distinction where a specialist is devoted to a subject or a particular branch within a subject. Accordingly, this attempted distinction is without merit.

[*15]

Plaintiff nonetheless contends that there was a reasonable belief that Dr. Semel satisfied the requirements of *MCL 600.2912d.* We disagree. In *Grossman v Brown, 470 Mich. 593, 595-596; 685 N.W.2d 198 (2004),* the defendant performed surgery on plaintiff's decedent. The defendant was board certified in the area of general surgery and also held a "certificate of special qualifications in vascular surgery." In preparation for litigation, the plaintiff's counsel researched the qualifications of defendant to obtain a qualified expert witness to satisfy the affidavit of merit requirement, *MCL 600.2912d.* The American Medical Association (AMA) website was searched where the defendant's qualifications indicated that he was board certified only in general surgery. There was no indication that the defendant held any board certification in vascular surgery. Based on this research, the plaintiff's counsel obtained an affidavit of merit from a physician board certified in general surgery, but who also specialized in vascular surgery. The defendant filed a motion for summary disposition, and the trial court denied [*16] the motion, concluding that the plaintiff's attorney had a reasonable belief that his expert satisfied the statutory prerequisites for an expert witness. *Id.* at 596-597.

The Supreme Court affirmed the trial court's denial of the dispositive motion, holding:

> Because this case presents a dispute involving the affidavit-of-merit stage, the issue before us is whether, according to *MCL 600.2912d(1)*, plaintiff's attorney had a "reasonable belief" that his expert satisfied the requirements of *MCL 600.2169.* We hold that given the information available to plaintiff's attorney when he was preparing the affidavit of merit, he had a reasonable belief that Drs. Brown and Zakharia were both board-certified in their specialty of general surgery and that there was no board certification in vascular surgery.
>
> The salient and dispositive facts are

that plaintiff's attorney consulted the AMA website, which supplied him with information that defendant Brown was only board-certified in general surgery and that there is no vascular surgery board certification. Further, counsel consulted Dr. Zakharia, his expert, who reiterated that [*17] there is no vascular surgery board certification.

Thus, at the moment the affidavit of merit was being prepared, plaintiff's attorney used the resources available to him and reasonably concluded that he had a match sufficient to meet the requirements for naming an expert. It may be that what satisfied the standard at this first stage will not satisfy the requirements of *MCL 600.2169* for expert testimony at trial. This will be decided on remand. To address this matter now, especially because there has been no fact-finding on the disputed factual questions, would be premature. It will be for the trial court, in its role as initial interpreter of the statute and qualifier of experts, to decide this issues as they become timely. [*Id.* at 599-600 (footnotes omitted).]

In the present case, plaintiff asserts that the reasonable belief requirement of *MCL 600.2912d* is satisfied because defendant was a general surgeon at the time of the alleged malpractice and an affidavit was obtained from a general surgeon. In the narrative portion of the brief, plaintiff's counsel asserts that the qualifications of the two surgeons were [*18] matched prior to the filing of the litigation and only discovery would have revealed that defendant was practicing in a subspecialty at the time of the malpractice. This blanket assertion is insufficient to oppose the motion for summary disposition. *Maiden, supra.* Plaintiff's counsel fails to delineate whether there was ever any research into the qualifications of defendant Dr. Wasvary and whether there was any attempt to match those qualifications with an expert for the purposes of filing an affidavit of merit with the complaint. n5 Accordingly, the trial court did not err in granting defendant's motion for summary disposition.

n5 Defendant attached deposition testimony from plaintiff's expert filed in other litigation. There is no indication that plaintiff's expert had performed any surgery within the area of expertise held by defendant. Plaintiff fails to delineate whether the qualifications and any experience in colon and rectal surgery by Dr. Semel was questioned by counsel.

Affirmed. [*19]

/s/ Richard Allen Griffin

/s/ Mark J. Cavanagh

/s/ Karen M. Fort Hood

LEXSEE 2005 US DIST LEXIS 2776

LUIS E. NUNEZ, MD, Plaintiff, v. TEMPLE PROFESSIONAL ASSOCIATES, et al., Defendants.

CIVIL ACTION NO. 03-CV-6226

UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

2005 U.S. Dist. LEXIS 2776

February 22, 2005, Decided

DISPOSITION: Defendants' motion for summary judgment was granted in part and denied in part. Plaintiff's cross-motion for summary judgment was denied.

LexisNexis(R) Headnotes

COUNSEL: [*1] For LUIS E. NUNEZ, MD, Plaintiff: KEITH S. ERBSTEIN, THE BEASLEY FIRM, PHILADELPHIA, PA.

For TEMPLE PROFESSIONAL ASSOCIATES, et al., Defendants: LISA MARIE SCIDURLO, KING OF PRUSSIA, PA; LARRY J. RAPPOPORT, STEVENS & LEE, KING OF PRUSSIA, PA.

JUDGES: Legrome D. Davis, J.

OPINIONBY: Legrome D. Davis

OPINION: MEMORANDUM

LEGROME D. DAVIS, J.

Presently before the Court is the Motion for Summary Judgment filed by Defendants Temple Professional Associates, Temple Physicians, Inc., and Temple University Health System Inc. on August 2, 2004 (Defs.' Mot., Doc. No. 7), the Cross-Motion for Summary Judgment filed by Plaintiff Luis E. Nunez on August 23, 2004 (Pl.'s Cross-Mot., Doc. No. 8), and the Brief in Opposition to Plaintiff's Cross-Motion for Summary Judgment on All Claims in Plaintiff's Complaint filed by the Defendants on September 17, 2004 (Defs.' Opp'n, Doc. No. 12).

For the reasons that follow, it is hereby ORDERED that Defendants' Motion is GRANTED with respect to Counts III and IV and DENIED with respect to Counts I and II. Plaintiff's Cross-Motion is therefore DISMISSED as moot with respect to Counts III and IV. Plaintiff's Cross-Motion is DENIED with respect to Counts I and II. [*2]

I. FACTUAL BACKGROUND AND PROCEDURAL HISTORY

The following facts are uncontroverted. Plaintiff Luis E. Nunez, M.D. is currently 67 years old. Pl. Depo. at 7. His employment relationship with the Defendants began in October 2001, at which time he was hired to provide services at the Comprehensive Health Center ("CHC") at the Episcopal Campus of Temple University Hospital. Specifically, Defendants hired Plaintiff to cover for David Stricklan, M.D. when Dr. Stricklan was absent from CHC. Defs.' Mot. at 4-5; Pl.'s Cross-Mot. at 5. On December 6, 2001, Plaintiff and Defendant entered into a part-time employment agreement, which provided that Plaintiff would work thirty-two (32) to forty (40) hours per week for Defendant Temple Professional Associates ("TPA"), n1 performing "the full range of professional services customarily performed by physicians engaged in the practice of general and family medicine." Pl.'s Cross-Mot at Ex. A. The contract was printed on letterhead bearing the names of both Defendant Temple University Health System ("TUHS") and Defendant TPA. Id. The contract stated that Plaintiff would be employed by Defendant TPA. Id. The impetus for this formal [*3] contractual arrangement was the permanent departure of Dr. Stricklan from CHC and the immediate need for a bilingual physician to take over Dr. Stricklan's patient schedule. Defs.' Mot. at 5.

> n1 As of July 2003, TPA no longer exists as a separate entity. During the course of Plaintiff's employment, Defendants maintain that he became an employee of Temple Physicians, Inc. ("TPI"). Defs.' Mot. at 3, n.3.

Plaintiff provided services at CHC pursuant to this

contract until March 2002, when Defendants hired Gladys Fion, M.D. who is approximately 30 years old, to fill Dr. Stricklan's former position at CHC on a full-time basis. Def.'s Mot. at 6; Pl.'s Cross-Mot. at 7, n.10. That same month, Defendants transferred Plaintiff to another practice, Temple Community Medical Center ("TCMC"), where a family practice position had opened up due to the retirement of Martin Munoz, M.D. Def.'s Mot. at 7; Pl.'s Cross-Mot. at 7-8. Plaintiff filled this position pursuant to his December 2001 contract until July 1, 2002, at which time [*4] Defendants notified Plaintiff that his last day would be July 2, 2002. In his termination notice, Defendants communicated to Plaintiff that he would be paid until August 24, 2002, as Defendants interpreted his contract to require 30 days notice before cessation of pay. Def.'s Mot. at 8; Pl.'s Cross-Mot. at 8-9. Plaintiff's termination was precipitated by Defendants' hiring of Daniel Hernandez, M.D., who had recently completed a residency in family practice, to fill the position vacated by Dr. Munoz on a full-time basis. Def.'s Mot. at 8. At the time of his termination, Plaintiff was 66 years old.

On or about September 22, 2002, Plaintiff filed a Charge of Discrimination with the Equal Employment Opportunity Commission ("EEOC") and the Pennsylvania Human Relations Commission. On or about August 27, 2003, the EEOC issued a Notice of Right to Sue. Plaintiff timely filed suit in this Court on October 28, 2003, alleging age discrimination under the Age Discrimination in Employment Act, *29 U.S.C. § 621 et seq.* ("ADEA") and the Pennsylvania Human Relations Act, *43 P.S. § 951 et seq.* ("PHRA"). In addition, Plaintiff also alleges that [*5] Defendants' actions constitute a breach of contract under Pennsylvania common law and a violation of the Employee Retirement Income Security Act, *29 U.S.C. § 1001 et seq.* ("ERISA").

II. STANDARD OF REVIEW

In considering a motion for summary judgment, the court must determine whether "the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue of material fact and that the moving party is entitled to judgment as a matter of law." *Fed. R. Civ. P. 56(c); Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 247, 91 L. Ed. 2d 202, 106 S. Ct. 2505 (1986); Arnold Pontiac-GMC, Inc. v. General Motors Corp., 786 F.2d 564, 568 (3d Cir. 1986).* Only facts that may affect the outcome of a case are "material," and a fact is considered to be material if "its existence or nonexistence might affect the outcome of the suit under the applicable law." *Anderson, 477 U.S. at 248.* All reasonable inferences from the record are drawn in favor of the non-movant. See *id. at 256.*

Although the movant [*6] has the initial burden of demonstrating the absence of genuine issues of material fact, the non-movant must then establish the existence of each element on which it bears the burden of proof. See *J.F. Feeser, Inc. v. Serv-A-Portion, Inc., 909 F.2d 1524, 1531 (3d Cir. 1990)* (citing *Celotex Corp. v. Catrett, 477 U.S. 317, 323, 91 L. Ed. 2d 265, 106 S. Ct. 2548 (1986))*, cert. denied, *499 U.S. 921, 113 L. Ed. 2d 246, 111 S. Ct. 1313 (1991).* A plaintiff cannot avert summary judgment with speculation or by resting on the allegations in his pleadings, but rather must present competent evidence from which a jury could reasonably find in his favor. *Anderson, 477 U.S. at 248; Ridgewood Bd. of Educ. v. N.E. for M.E., 172 F.3d 238, 252 (3d Cir. 1999); Williams v. Borough of West Chester, 891 F.2d 458, 460 (3d Cir. 1989); Woods v. Bentsen, 889 F. Supp. 179, 184 (E.D. Pa. 1995).*

III. CLAIMS AGAINST TEMPLE UNIVERSITY HOSPITAL SYSTEM

Defendants argue that TUHS is entitled to summary judgment on all claims against it, as Plaintiff has not established an employment relationship with that entity. Defs.' Mot. at 3. n. [*7] 3. Defs.' Opp'n at 16. Plaintiff answers that TUHS is a proper defendant in this case pursuant to Pennsylvania agency law and the "integrated enterprise" test articulated by federal courts in dealing with cases where both a parent and a subsidiary are named defendants in an ADEA case. Pl.'s Cross-Mot. at 36-37.

The "integrated enterprise" test was developed by courts to help resolve cases in which a plaintiff attempts to hold two corporations liable as a single employer for violations of a statute prohibiting discrimination in employment. See *Gorman v. Imperial Metal & Chemical Co., 1999 U.S. Dist. LEXIS 1810, 1999 WL 124463, *3 (E.D. Pa. 1999).* Under this test, a court considers the following characteristics of the parent and subsidiary corporations: (1) the interrelation of operations, (2) common management, (3) common control of labor relations, and (4) common ownership or financial control. Id. (citing *Kamens v. Summit Stainless, Inc., 586 F. Supp. 324, 327 (E.D. Pa. 1984)).* No singular factor is controlling. Id.

The Court finds that, as a matter of law, TUHS was Plaintiff's employer for purposes of the ADEA and PHRA. The employment contract entered into by Plaintiff [*8] and TPA, as well as the letter informing him of his termination, at which time Defendant claims Plaintiff was an employee of TPI, was printed on TUHS stationary. Pl.'s Cross-Mot. at Ex. A; Ex. D. The employment contracts signed by Drs. Fion and Hernandez were entered into between those doctors and TPA, which is defined in those contracts as "a Pennsylvania nonprofit corporation formed

for the purpose of providing physician services to patients and to provide services to the Temple University Health System, Inc. and its affiliated hospitals." Id. at Ex. E; Ex. F. In his deposition testimony, Mr. James Larson, the current Chief Operating Officer of TPI, testified that TUHS handles all human resource needs for TPI and TPA. Larson Depo. at 81-82; Mankin Depo. at 201 ("Personnel is a department that we don't staff. We buy that service from [TUHS]."). This is confirmed, in part, by a printout from "Temple University Hospital" detailing Plaintiff's work history with Defendants; the printout contains a weekly summary of the number of hours worked, the hourly rate at which he was paid, and his gross weekly pay. Pl.'s Cross-Mot. at Ex. Q. Moreover, Dr. Eric Mankin, the current CEO of TPI, [*9] testified at his deposition that he also served on the senior management of TUHS Leadership and that he spent a "fair amount of [his] time at the TUHS Center campus." Mankin Depo. at 6. Makin also testified that management of TPA and TPI reported to management of TUHS and that the TUHS Board oversaw and continues to oversee the business operations of TPI. Mankin Depo. at 10. Given the interrelated operations, common management, and common control of labor relations that exist between TPA, TPI, and TUHS, the Court finds that TUHS is a proper defendant in this matter.

IV. ADEA AND PHRA CLAIMS

Plaintiff alleges that Defendants impermissibly terminated his employment based on his age. The ADEA makes it "unlawful for an employer . . . to fail or refuse to hire or to discharge any individual or otherwise discriminate against any individual with respect to his compensation, terms, conditions, or privileges of employment, because of such individual's age." *29 U.S.C. § 623(a)(1)*. A plaintiff who alleges disparate treatment must show that "the protected trait (under the ADEA, age) actually motivated the employer's decision." *Reeves v. Sanderson Plumbing Products, Inc. 530 U.S. 133, 141, 147 L. Ed. 2d 105, 120 S. Ct. 2097 (2000)* [*10] (citing *Hazen Paper Co. v. Biggins, 507 U.S. 604, 610, 123 L. Ed. 2d 338, 113 S. Ct. 1701 (1993))*. A plaintiff therefore bears the burden of proving by a preponderance of the evidence that age "actually played a role in [the employer's decision-making] process and had a determinative influence on the outcome." Id.

Where a plaintiff's case is based principally on circumstantial evidence of discrimination, the burden-shifting analysis of *McDonnell Douglas Corp. v. Green, 411 U.S. 792, 36 L. Ed. 2d 668, 93 S. Ct. 1817 (1973)*, is the appropriate framework for analysis of both ADEA and PHRA claims: (1) Plaintiff must establish a *prima facie* case by a preponderance of the evidence; (2) Defendant then must produce a legitimate nondiscriminatory reason for the adverse employment decision; and (3) Plaintiff must demonstrate by a preponderance of the evidence that Defendant's stated reason is a mere pretext for illegal discrimination. *Id. at 802* & n.13; *Jones v. Sch. Dist. of Philadelphia, 198 F.3d 403, 410 (3d Cir. 1999)*; *Allegheny Housing Authority v. Commonwealth of Pennsylvania PHRC, 516 Pa. 124, 532 A.2d 315, 316-18 (Pa. 1987)* [*11] (adopting the McDonnell Douglas Corp. framework for analysis of PHRA claims). Though the burden of production shifts between the parties, the burden of persuasion as to whether the employer-defendant's actions were motivated by age rests with the plaintiff at all times. *Gray v. York Newspapers, 957 F.2d 1070, 1078 (3d. Cir. 1992)* (citation omitted).

A. Prima Facie Case

Plaintiff claims that Defendants impermissibly discriminated against him on the basis of his age by replacing him at CHC with Dr. Fion and by replacing him at TCMC with Dr. Hernandez. Pl. Compl. at P 46a. Defendants claim that Plaintiff has not made out a prima facie case, as he has not shown that he was qualified to hold either the position at CHC or TCMC on a full-time basis. Defs.' Mot. at 13.

To make out a prima facie case of discrimination, Plaintiff must show that: (1) he is a member of a protected class; (2) he was qualified for his position; (3) despite his qualifications, he suffered some form of adverse employment action; and (4) the adverse employment action took place under circumstances that give rise to an inference of unlawful discrimination. See *Jones, 198 F.3d at 411*; [*12] *Waldron v. SL Indus., Inc., 56 F.3d 491, 494 (3d Cir. 1995)*; *Pivirotto v. Innovative Sys., Inc., 191 F.3d 344, 356-57 (3d Cir. 1999)*. Defendants do not dispute that Plaintiff was in the protected class, that he suffered an adverse employment action, or that Drs. Fion and Hernandez are sufficiently younger than Plaintiff. n2 The crux of whether Plaintiff can make out a *prima facie* case in the instant ADEA claim is whether Plaintiff was qualified to fill the full-time positions that were ultimately given to Doctors Fion and Herndandez.

> n2 Courts within the Third Circuit have consistently held that the satisfaction of the fourth element of a prima facie case requires proof of an age difference of at least seven years. See, e.g., *Fakete v. Aetna, Inc., 152 F. Supp. 2d 722, 735 (E.D. Pa.2001)* ("For satisfaction of the fourth element, courts generally require proof that the plaintiff was replaced by a person who is younger than he by at least seven years."); *Gutknecht v. SmithKline Beecham Clinical Lab., 950 F. Supp. 667, 672 (E.D. Pa.1996)* ("It is generally accepted that when

> the difference in age between the fired employee and his or her replacement is fewer than five or six years, the replacement is not considered 'sufficiently younger,' and thus no prima facie case is made."). In the instant case, Dr. Fion is approximately 30 years old and Dr. Hernandez has only recently completed his residency program, which indicates that he is much younger than a physician with the educational and practical experience of Plaintiff. Defendant has produced no evidence to the contrary.

[*13]

As a threshold issue, Defendant's claim that Plaintiff was not qualified because he lacked board eligibility/certification is more properly considered during the pretext stage of the Court's analysis. In *EEOC v. Horizon/CMS Healthcare Corp., 220 F.3d 1184 (10th Cir. 2000)*, the Tenth Circuit declined to allow a defendant to use its legitimate non-discriminatory reason as a barrier to a plaintiff's establishment of a *prima facie* case, as it found that "to hold otherwise would be tantamount to collapsing the first and second stages of the McDonnell Douglas analysis and would deny a plaintiff the opportunity to demonstrate that the defendant's explanation for the adverse employment action is pretextual." *Id. at 1193.* The Court finds this reasoning to be persuasive and will therefore not consider Defendant's lack of board eligibility/certification to be an impediment to his showing of a *prima facie* case of age discrimination.

Plaintiff has produced evidence sufficient to make a *prima facie* case that he was qualified for full-time employment with Defendants. A plaintiff can satisfy his burden at the prima facie stage by introducing some [*14] credible evidence that he possesses the objective qualifications necessary to perform the job sought. See, e.g., *EEOC, 220 F.3d at 1193-94* (citations omitted). Plaintiff has had significant medical training and practice as a surgeon and family practice physician. With respect to his formal educational training, Plaintiff has offered uncontroverted evidence that he (1) completed a residency in cardio-thorasic surgery at Hahnemann University from 1957 to 1961, which included a year specializing in the field of cardiology, (2) that he had an internship in medicine at Albert Einstein Medical Center in or about 1962, (3) that he completed a fellowship in pulmonary physiology in or about 1963, and that (4) he completed a residency in general surgery from 1966 to 1970, which included some pediatrics training. n3

> n3 In the interim years between his fellowship and general surgery residency, Plaintiff took graduate courses at Drexel University in Biomedical Engineering.

In addition, Plaintiff's practical [*15] work experience is substantial. Plaintiff was the Chief of Cardio-Thorasic Surgery at Dos de Mayo Hospital for approximately one year in or around 1961, a cardio-thorasic surgeon for one year at Einstein from 1965 to 1966, an emergency room physician at Frankfort Hospital from 1971 to 1973, and a general surgeon for almost twenty years from 1973 to 1992. Beginning in 1976, Plaintiff also maintained his own internal/family medicine practice; he practiced family medicine exclusively after he ceased his general surgery activities in 1992. In 1994, Plaintiff began to supplement his private practice by working as a family practice physician for Lehigh Physicians, Inc. at two of its clinics, including one at Episcopal Hospital. Plaintiff began to exclusively work at his private practice again in 1998 when Defendant Temple University Health System, Inc. acquired Episcopal Hospital, but not Lehigh Physicians, which subsequently dissolved. Defs.' Mot. at 3.

Beyond his educational and practical experience, the record reflects that Plaintiff was also bilingual, a skill that Defendants considered essential to work in the community care facilities that Plaintiff staffed for them, as the communities [*16] those clinics serviced were largely Spanish-speaking. Mankin Depo. at 98. In addition, Defendants do not argue that Plaintiff was not a competent employee. Dr. Mankin, in his deposition testimony, stated that he could not recall receiving any complaints about Plaintiff's performance at any point during his tenure at Defendants' facilities. Mankin Depo. at 140.

Given Plaintiff's extensive *curriculum vitae* and his unblemished work record while in the employ of the Defendants, the Court finds that Plaintiff has sufficiently shown that he was qualified for a permanent physician position and therefore has carried his burden of establishing a *prima facie* case of age discrimination.

B. Defendant's Legitimate, Nondiscriminatory Reason

Once Plaintiff establishes a prima facie case, "'the burden of production (but not the burden of persuasion) shifts to the defendant, who must then offer evidence that is sufficient, if believed, to support a finding that the defendant had a legitimate, nondiscriminatory reason for the [adverse employment decision].'" *Showalter v. University of Pittsburgh Medical Center, 190 F.3d 231, 235 (3d Cir. 1999)* (quoting *Keller v. Orix Credit Alliance, Inc., 130 F.3d 1101, 1108 (3rd Cir. 1997)*; [*17] see also *Smith v. Borough of Wilkinsburg, 147 F.3d 272, 278 (3rd. Cir. 1998).*

Defendants have stated that the reason they chose to exercise their option to terminate Plaintiff under their interpretation of his employment contract rather than retaining him on a full-time basis was his lack of Board eligibility and/or Board certification. Def.'s Mot. at 14. As such, the burden shifts to Plaintiff to show that this reasons was pretextual.

C. Pretext

Once a Defendant produces a non-discriminatory reason for the adverse employment decision, the burden shifts back to the Plaintiff, who must submit evidence from which a factfinder could reasonably either (1) disbelieve the employer's articulated legitimate reasons; or (2) believe that an invidious discriminatory reason was more likely than not a motivating or determinative cause of the employer's action. *Keller v. Orix Credit Alliance, Inc., 130 F.3d 1101, 1108 (3d Cir. 1997)*; *Fuentes v. Perskie, 32 F.3d 759, 763 (3d Cir. 1994)*. Pretext is not demonstrated by showing simply that the employer was mistaken. *Sempier v. Johnson & Higgins, 45 F.3d 724, 731 (3d Cir. 1995)* [*18] (citing *Ezold v. Wolf, Block, Schorr and Solis-Cohen, 983 F.2d 509, 531 (3d Cir. 1992)*, cert. denied, *510 U.S. 826, 126 L. Ed. 2d 56, 114 S. Ct. 88 (1993)*). Instead, the Court examines the record for "evidence of inconsistencies or anomalies that could support an inference that the employer did not act for its stated reasons." Id. (citing *Josey v. John R. Hollingsworth Corp., 996 F.2d 632, 638 (3d Cir. 1993)*).

Under the first prong of the disjunctive test articulated above, a plaintiff-employee can defeat a defendant-employer's motion for summary judgment by directly or circumstantially discrediting the employer's proffered reason. In Fuentes v. Perskie, the Third Circuit explained that

> to discredit the employer's proffered reason, however, the plaintiff cannot simply show that the employer's decision was wrong or mistaken, since the factual dispute at issue is whether discriminatory animus motivated the employer, not whether the employer is wise, shrewd, prudent, or competent. Rather, the nonmoving plaintiff must demonstrate such weaknesses, implausibilities, inconsistencies, incoherencies, or contradictions in the employer's proffered [*19] legitimate reasons for its action that a reasonable factfinder *could* rationally find them unworthy of credence, and hence infer that the employer did not act for [the asserted] non-discriminatory reasons.

Fuentes, 32 F.3d at 765.

The Court finds that a reasonable trier of fact could rationally disbelieve that Defendants terminated Plaintiff because he was not Board certified or Board eligible. A proper beginning for a discussion of the Defendants' alleged policy is the definition of the terms "Board certified" and "Board eligible." Board certification is a process by which a physician becomes credentialed as a specialist in his or her chosen field. Each medical specialty has its own Board that sets requirements for becoming certified; the American Board of Medical specialties oversees these Member Boards in their awards of certification. *See* Pl.'s Cross-Mot. at Ex. J (American Board of Medical Specialties website); Ex. K (American Board of Family Practice website and certification requirements); Ex. L (American Board of Internal Medicine website and certification requirements). As opposed to the clear status of a physician who is Board certified, [*20] the status of a physician who is merely .board eligible. is more ambiguous. The American Board of Medical Specialities has published the following explanation of that term:

> The specific term "board eligible" has been given such diverse meanings by different agencies that it has lost its usefulness as an indicator of a physician's progress toward certification by a specialty board. Furthermore, because some candidates have used the term year after year while making no perceptible progress toward certification, it has sometimes been accepted improperly as a permanent alternative to certification. The requirements for admission to the certification process change from time to time, making the term "board eligible" equally susceptible to changes in meaning. For these reasons, the ABMS recommends to its Member Boards that the use of the term "board eligible" be disavowed.

Pl.'s Cross-Mot. at Ex. J. Dr. Mankin testified that he understood that a physician who is "Board eligible" is "a physician . . . who qualifies to sit for Board certification. . . . In every case that I am aware of, [it] refers to physicians who have successfully completed an accredited residency in their [*21] specialty of choice, such that they're able to sit for the written or oral exam." Makin Depo. at 30-31.

Dr. Mankin is responsible for the hiring and firing of the physicians who staff the 32 sites managed by TPI. Defs.' Mot. at 3. Dr. Mankin testified that there was a requirement that any physician hired without a substantial

practice of their own be Board eligible or Board certified "in an appropriate speciality conducive to the care of the patients [they] were expected to provide services for." Mankin Depo. at 19-20. Mankin testified that he had personally employed his policy in requiring candidates to be Board certified or Board eligible in making physician personnel decisions since 1996. Mankin Depo. at 20. Dr. Mankin estimates that, in the past two years, Board eligible or Board certified physicians have made up approximately 91 percent of all physicians employed by TPI. Mankin Depo. at 22. He explained that his reason for implementing this policy was "to have the highest quality and best-trained group of physicians caring for [Defendants.] patients" that he could find. Mankin Depo. at 30.

Plaintiff first argues that Defendants never actually had any formal policy in place [*22] that required physicians to be Board certified or Board eligible. The testimony of high-ranking employees of Defendants and a review of its internal documents does not conclusively disprove Plaintiff's assertion. Mr. Larson described the policy as "informal" and testified that Dr. Mankin had told the Board of Directors that it was his goal to have as close to 100 percent Board certified doctors as possible. Larson Depo. at 38. He further stated that he knew of "no written documents . . . no written policies" that memorialized this physician employment requirement, a statement that is uncontested by Dr. Mankin. Larson Depo. at 38; Mankin Depo. at 20-21. Moreover, the Temple University Hospital, Inc. Bylaws of the Professional Medical Staff detail the qualifications necessary to be a member of that organization's medical staff in some capacity. The qualifications for physicians, podiatrists and dentists include being professionally competent and licensed in the Commonwealth of Pennsylvania. Pl.'s Cross-Mot. at Ex. I, p.6. The very next sentence in the Bylaws states that "other health care practitioners must also be licensed in the Commonwealth of Pennsylvania *and/or certified by their* [*23] *speciality*." Id. (emphasis added). The absence of a certification requirement in the sentence describing physician qualifications, as opposed to those for other health care providers, lends credence to Plaintiff's contention that Board certification was not an objective qualification actually required by Defendants.

Plaintiff's contention that the policy was an informal preference rather than an objective policy is bolstered by the inconsistency of Defendants' application of the Board certification/eligibility requirement. The record reveals that while some physicians were required to be Board certified or merely Board eligible, some were absolutely required to be Board certified, while still others were apparently not required to be either. In their motion for summary judgment, Defendants state that Dr. Mankin did not require some physicians to be board certified/eligible, namely those that had an appropriate amount of "training, experience, and the substantial financial success of their private practices." Defs.' Mot. at 11. One example of this practice is Dr. Munoz, who remained with Defendants until his retirement in his mid-70s, and who was neither Board certified or eligible. [*24] Mankin Depo. at 26-27. In another case, Dr. Mankin communicated to Dr. Stricklan that he needed to become Board certified to remain in his position as a full-time physician, despite the fact that he was already Board eligible and therefore objectively qualified under Defendants' articulated policy. n4 See Mankin Depo. at 96. Moreover, a reasonable trier of fact could look beyond these two specific examples to the fact that Defendants made exceptions to the alleged overall policy amounting to ten percent of their employed physicians and could rationally disbelieve that Defendants were even-handedly requiring that full-time physicians be Board certified/eligible.

> n4 It is worth noting here that Dr. Stricklan was, by Defendants' own admission, 44 years old at the time of his departure, which would place him in the protected class with Plaintiff. Defs.' Opp'n at 13.

While the Court agrees with Defendants that not every employment policy needs to be reduced to writing to be a legitimate, non-discriminatory basis [*25] for making employment decisions, it believes that this particular policy's lack of documentation, combined with its uneven application, raises a permissible and reasonable inference that the policy was not the true reason that Plaintiff's employment with Defendants was terminated. As a reasonable trier of fact could rationally conclude that Defendants were using the Board certification policy as a pretext for impermissible discrimination, Plaintiff's ADEA and PHRA claims survive Defendant's motion for summary judgment.

The Court does not believe, however, that summary judgment is in Plaintiff's favor is appropriate on Plaintiff's ADEA and PHRA claims. While Plaintiff has met his burden of casting doubt upon Defendant's proffered reason for terminating him, the Court finds that he has not produced evidence such that no reasonable jury could find that Defendants acted with discriminatory intent as a matter of law. Because a material question of fact exists as to whether Defendants. actions constituted improper discrimination on the basis of Plaintiff's age, the Court will deny Plaintiff's cross-motion for summary judgment on his ADEA and PHRA claims.

V. BREACH OF CONTRACT CLAIM [*26]

In Count III of the Complaint, Plaintiff alleges that Defendants' termination of him without cause and in bad faith constituted a material breach of his employment agreement, entitling him to damages therefrom. Pl.'s Compl. at PP 66-67. Defendants assert that they are entitled to summary judgment on Plaintiff's contract claim as they notified Plaintiff of his separation from their employment in accordance with the terms of his contract and compensated him accordingly. Defs.' Mot. at 18.

Two sections of the employment contract between the parties are at issue here. Paragraph 1 states that "The effective date of this arrangement shall be January 2, 2002, and shall continue in effect for a period of one (1) year until January 1, 2003." Pl.'s Cross-Mot. at Ex. A. Paragraph 11 reads "Your part time employment shall continue for a period of one (1) year unless terminated earlier. Either party may terminate this arrangement at any time by providing a thirty (30) day notice to the other party." Id. The parties have conflicting interpretations as to how these two paragraphs define the term of Plaintiff's employment. These conflicting interpretations lead Plaintiff to conclude that he [*27] had a one-year employment contract with Defendants, which could only be terminated for good cause. Pl.'s Cross-Mot. at 10. For their part, Defendants characterize the contract as providing them with the ability to terminate Plaintiff without cause, so long as the thirty day notice provision is satisfied.

The Court believes that neither Defendants' nor Plaintiff's interpretation of the contract language and that interpretation's legal ramifications are entirely correct. "The presumption under Pennsylvania law is that all employment is at-will, and, therefore, an employee may be discharged for any reason or no reason." *Luteran v. Loral Fairchild Corp., 455 Pa. Super. 364, 688 A.2d 211, 214 (Pa. Super. 1997)* (citing *Scott v. Extracorporeal, Inc., 376 Pa.. Super. 90, 376 Pa. Super. 90, 545 A.2d 334 (1988))*. Therefore, no cause of action lies against an employer for the termination of an at-will employee. Id. In order to rebut the presumption of at-will employment, a party must establish that one of the following is present: "(1) an agreement for a definite duration; (2) an agreement specifying that the employee will be discharged for just cause only; (3) sufficient [*28] additional consideration; or (4) an applicable recognized public policy exception." *Janis v. AMP, Inc., 2004 PA Super 301, 856 A.2d 140, 144 (Pa. Super. 2004)* (citing *Rapagnani v. The Judas Company, 1999 PA Super 203, 736 A.2d 666, 669 (Pa. Super. 1999))*. See also *Luteran, 688 A.2d at 214* (citation omitted). A presumption of at-will employment applies to an employment agreement that lacks a definite term of employment,. Id (citing *Rapagnani, 736 A.2d at 670*). If a term of employment does exist, an employer may not terminate an employee for the duration of that term in the absence of just cause. *Greene v. Oliver Realty, Inc., 363 Pa. Super. 534, 526 A.2d 1192 (Pa. Super. 1987)*. The party asserting that good cause is required bears the burden of showing, by a preponderance of the evidence, that the employment contract was for a definite time. *Id. at 1196*.

The Court finds that Plaintiff's employment contract contained an agreement for a definite duration of time, overcoming the presumption of at-will employment. In *Schecter v. Watkins, 395 Pa. Super. 363, 577 A.2d 585 (Pa. Super. 1990)*, the Superior [*29] Court of Pennsylvania examined an employment contract between an physician and a medical corporation that contained language virtually identical to that in Paragraph 11 of the instant contract. The contract in that case stated that "The term of this Agreement shall be one (1) year from the date set forth unless either party shall give ninety (90) day notice of their intention to terminate the agreement prior to the end of the term." *Id. at 587*. The Court found that the contract expressly limited the employer's ability to discharge its employees and set forth the conditions under which those employees could be terminated. In the instant case, the contract expressly provides for a one year term of employment with thirty days notice required for termination of the agreement by either party. As the Third Circuit has noted in its examination of Pennsylvania contract law, "the requirement of notice is antithetical to the very definition of employment at-will." *Carlson v. Arnot-Ogden Memorial Hospital, 918 F.2d 411, 414 (3d Cir. 1990)* (citations omitted). The Court finds that there is no question of fact as to whether the contract at hand contains a definite [*30] term of employment.

Plaintiff has shown that his contract did not create an at-will employemnt situation; however, the Court finds that no reasonable trier of fact could conclude that Defendants are in breach of that agreement. The Schecter court noted that even though the contract contained a term of employment, it also expressly provided that either party could terminate the agreement without a required showing of cause. *Schecter, 577 A.2d at 590*. The Court declined to impose a good cause requirement on the contract in the face of explicit language permitting termination and setting forth procedures for that action. n5 As such, because the plaintiff in Schecter did not allege that he was not given the requisite ninety days notice, the lower court's judgment in favor of the defendant-employer was upheld. *Id.* The contract here contains the exact language of the contract in that case, though the number of days notice required is slightly different. Plaintiff was terminated on July 2, 2002 and Defendants continued to compensate him until August 24, 2002, well beyond the thirty days required by the contract. Plaintiff does not allege that the contract itself [*31] is not the result of a bargained-for

exchange. As such, the Court finds that summary judgment in favor of Defendants is appropriate on the breach of contract claim.

n5 The Third Circuit reached a similar conclusion using an alternative analysis in Carlson v. Arnot-Odgen Memorial Hospital, in which the court considered a contract in which either party could terminate the employment relationship by giving the other party ninety days notice. The Third Circuit concluded that the notice provision overcame the presumption of at-will employment by creating a contract with a term of at least ninety days. The defendant-hospital's failure to provide the appropriate notice in Carlson resulted in its liability for a breach of a ninety day contract. *Carlson, 918 F.2d at 414-15.*

VI. ERISA CLAIM

Count IV of Plaintiff's Complaint asserts that Defendants deliberately misclassified Plaintiff as a part-time employee in order to avoid paying him benefits that he was entitled to under ERISA. [*32] Pl.'s Compl. at PP 68-70. Defendants assert that summary judgment is appropriate on this claim as a matter of law, as there is no cause of action under ERISA for misclassification. Def.'s Opp'n at 18. Defendants also claim that, even if there were a cause of action under ERISA for misclassification, Plaintiff has failed to exhaust his administrative remedies. Id.

In his complaint, Plaintiff does not mention under which section of ERISA his claim is brought. In his cross-motion for summary judgment, he cites *29 U.S.C. § 1132(a)(1)(B)*, which states that:

> A civil action may be brought
> (1) by a participant or beneficiary
> . . .
> (A) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to further benefits under the term of terms of the plan.

29 U.S.C. § 1132(a)(1)(B).

The Court finds that Plaintiff has not come forward with any evidence that would allow his claim to survive summary judgment. Specifically, Plaintiff has not produced any evidence that (1) Defendants offered a benefits plan covered by ERISA; (2) that he was a "participant" [*33] of that plan, as defined at *29 U.S.C. § 1002*, n6 or *(3)* that he exhausted his administrative remedies under that plan or that an exception to the exhaustion requirement is warranted because resort to the administrative process is futile. n7 See *Weldon v. Kraft, Inc., 896 F.2d 793, 800 (3d Cir.1990)* ("Except in limited circumstances . . . a federal court will not entertain an ERISA claim unless the plaintiff has exhausted the remedies available under the plan.") (citing *Wolf v. Nat'l Shopmen Pension Fund, 728 F.2d 182, 185 (3d Cir.1984))*; *Berger v. Edgewater Steel Co., 911 F.2d 911, 916 (3d Cir.1990)* (recognizing an exception to the exhaustion rule for futility); *Harrow v. Prudential Ins. Co. of America, 279 F.3d 244, 249 (3d Cir. 2002)* (requiring a "clear and positive showing of futility."). As Plaintiff has not come forth with evidence of the most basic elements of his ERISA claim, the Court accordingly grants summary judgment to the Defendants.

n6 Participant is defined as "any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer or members of such organization, or whose beneficiaries may be eligible to receive any such benefit." *29 U.S.C. § 1002(2)(B)(7).*

[*34]

n7 Plaintiff's claim that he has somehow attempted to exhaust his ERISA claim by filing a claim with the EEOC that he was denied full-time benefits is insufficient to create a material issue of fact on this matter. The exhaustion requirement clearly relates to the administrative process set up by the plan itself and no other administrative process.

VII. CONCLUSION

An appropriate Order follows.

ORDER

AND NOW, this 22nd day of February, 2005, it is hereby ORDERED that the Motion for Summary Judgment filed by Defendants Temple Professional Associates, Temple Physicians, Inc., and Temple University Health System Inc. on August 2, 2004 (Defs.' Mot., Doc. No. 7) is GRANTED in part and DENIED in part. Defendants' Motion is GRANTED with respect to Counts III and IV and DENIED with respect to Counts I

and II.

It is further ORDERED that the Cross-Motion for Summary Judgment filed by Plaintiff Luis E. Nunez on August 23, 2004 (Pl.'s Cross-Mot., Doc. No. 8) is DISMISSED in part and DENIED in part. Plaintiff's Cross-Motion is DISMISSED as moot with respect to Counts III and IV and DENIED with [*35] respect to Counts I and II.

BY THE COURT:

/s/

Legrome D. Davis, J.

LEXSEE 1999 MICH APP LEXIS 2571

PAULINE SHENDUK, Plaintiff-Appellant, v HARPER HOSPITAL and JOSEPH G. TALBERT, M.D., Defendant-Appellees.

No. 199547, 200389

COURT OF APPEALS OF MICHIGAN

1999 Mich. App. LEXIS 2571

October 29, 1999, Decided

PRIOR HISTORY: Wayne Circuit Court. LC Nos. 96-619269-NH, 96-641382-NH.

DISPOSITION: Affirmed.

JUDGES: Before: Whitbeck, P.J., and MacKenzie and Murphy, JJ. William B. Murphy, J., concurring and dissenting.

OPINION: PER CURIAM.

In Docket No. 199547, plaintiff Pauline Shenduk appeals by leave granted from an order dismissing her medical malpractice complaint in lower court docket number 96-619269-NH for failure to file an affidavit of merit that complied with *MCL 600.2912d*; MSA 27A.2912(4). In Docket No. 200389, which involved a later filed but essentially identical medical malpractice complaint, Shenduk appeals as of right an order granting summary disposition in favor of defendants Harper Hospital and Joseph G. Talbert, M.D., based on the statute of limitations. We affirm.

I. Factual Background And Procedural History

In March 1996, Shenduk filed a complaint against defendants Harper Hospital and Dr. Talbert. In this complaint, Shenduk alleged that she reported to Harper Hospital, under the care of Dr. Talbert, on April 1, 1994, and that [*2] coronary artery bypass surgery was performed on April 2, 1994. n1 Shenduk further alleged that she was administered the medication heparin from April 1, 1994, to April 4, 1994, and that "platelet counts taken during this period of time were within normal limits." According to the complaint, on April 7, 1994, Shenduk "began to complain of signs and symptoms consistent with deep vein thrombosis in her left lower extremity," and she was administered the medications heparin and coumadin from April 7, 1994, to April 12, 1994. A platelet count taken on April 12, 1994, was "abnormally low at 75,000," while a platelet count on April 13, 1994, was "abnormally low at 61,000." Shenduk alleged that she was "subsequently diagnosed with heparin induced thrombocytopenia, white clot syndrome and heparin allergy" and that, on April 13, 1994, she "was forced to undergo a left, above the knee, amputation as a result of thrombosis in her left leg due to her reaction to heparin." Shenduk alleged that each defendant was negligent

> in that a reasonable and prudent licensed and practicing health care provider, when presented with a patient exhibiting the medical history and signs and symptoms such [*3] as those manifested by Ms. Shenduk, owes a duty to timely and properly:
>
> a. Maintain an awareness of the potential for the development of heparin induced thrombocytopenia, white clot syndrome or heparin allergy and assess a patient's response to heparin by performing platelet counts and tests for platelet associated immunoglobulin G.
>
> b. In the presence of decreased platelet count, increased platelet associated immunoglobulin G, and signs and symptoms of vascular thrombosis, discontinue use of heparin and include heparin induced thrombocytopenia, white clot syndrome or heparin allergy in the [] differential diagnosis. n2

n1 While not expressly stated in the complaint, it appears undisputed that Dr. Talbert performed this surgery.

n2 Shenduk later field an amended complaint

> which added Ronald Kline, M.D., as a defendant. However, it appears that Dr. Kline was never served with process and has never been an active party to this suit.

A document entitled "Plaintiff's Affidavit of Meritorious [*4] Claim" was attached to the complaint. This document consisted of an affidavit signed by Louis Fiore, M.D., indicating that in his opinion the acts and omissions that Shenduk alleged to be negligent constituted a violation of the applicable standard of care. This affidavit included no designation or description of the nature of Dr. Fiore's medical practice or training and did not state whether he was a specialist in any area of medical practice.

As we will address in detail below, defendants essentially moved for dismissal of the action in lower court docket number 96-619269-NH on the ground that the purported affidavit of merit filed by Shenduk failed to comply with *MCL 600.2912d*; MSA 27A.2912(4) and *MCL 600.2169(1)(a)*; MSA 27A.2169(1)(a) because Dr. Fiore was not a board certified specialist in the same medical specialty as Dr. Talbert. Specifically, Dr. Talbert was a board certified thoracic surgeon specializing in cardiothoracic surgery while Dr. Fiore was not. The trial court eventually dismissed the action without prejudice after concluding that the purported affidavit of merit did not satisfy *MCL 600.2912d(1)* [*5] ; MSA 27A.2912(4)(1) because Shenduk's attorney could not have reasonably believed that Dr. Fiore would qualify as an expert witness in this case under *MCL 600.2169*; MSA 27A.2169.

On September 25, 1996, Shenduk filed another medical malpractice action in the lower court in docket number 96-641382-NH with a complaint stating essentially identical medical malpractice claims against defendants. However, that complaint was accompanied by an affidavit of merit signed by Thomas O'Grady, M.D., who apparently was board certified in cardiothoracic surgery. The trial court granted summary disposition in favor of defendants under *MCR 2.116(C)(7)* because the complaint had not been filed within the applicable two-year statute of limitations.

II. Standards Of Review

A. No. 199547 - Dismissal of Complaint

Generally, we review a decision to grant a motion for involuntary dismissal for clear error. *Phillips v Deihm, 213 Mich App 389, 397; 541 NW2d 566 (1995).* However, Shenduk argues in part that *MCL 600.2169*; MSA 27A.2169 is unconstitutional. This is a question of law that we review de novo. *McDougall v Schanz, 461 Mich 15;* [*6] *597 NW2d 148* (rel'd 7/30/99), slip op at 8.

B. No. 200389 - Summary Disposition

We review an order granting summary disposition de novo. *Novak v Nationwide Mutual Ins Co, 235 Mich. App. 675, 681; 599 NW2d 546 (1999).* In reviewing a grant of summary disposition under *MCR 2.116(C)(7)*, "we must take the well-pleaded allegations in the pleadings and the factual support submitted by the nonmoving party as true, and summary disposition is proper only if the moving party is then shown to be entitled to judgment as a matter of law." *Home Ins Co v Detroit Fire Extinguisher Co, Inc, 212 Mich App 522, 527-528; 538 NW2d 424 (1995).*

III. No. 199547

A. Compliance With *MCL 600.2912d*; MSA 27A.2912(4)

Shenduk argues that the trial court erred in dismissing her complaint because Shenduk's counsel reasonably believed that the purported affidavit of merit from Dr. Fiore that was filed with the complaint complied with the requirements of *MCL 600.2912d*; MSA 27A.2912(4). We disagree.

MCL 600.2912d(1); MSA 27A.2912(4)(1) provides in pertinent [*7] part that

> the plaintiff in an action alleging medical malpractice or, if the plaintiff is represented by an attorney, the plaintiff's attorney shall file with the complaint an affidavit of merit signed by a health professional who the plaintiff's attorney *reasonably believes* meets the requirements for an expert witness under [*MCL 600.2169*; MSA 27A.2169 (emphasis supplied)].

MCL 600.2169(1); MSA 27A.2169(1), in turn, provides in pertinent part:

> In an action alleging medical malpractice, a person shall not give expert testimony on the appropriate standard of practice or care unless the person is licensed as a health professional in this state or another state and meets the following criteria:
>
> (a) If the party against whom or on whose behalf the testimony is offered is a specialist, specializes at the time of the occurrence that is the basis for the action in the same specialty as the party against whom or on whose behalf the testimony is offered. *However, if the party against whom or on whose behalf*

> *the testimony is offered is a specialist who is board certified, the expert witness must be a specialist who* [*8] *is board certified in that specialty*. [Emphasis supplied.]

In this case, the evidence was undisputed that Dr. Talbert was board certified in general surgery and in thoracic surgery with a specialty in cardiothoracic surgery. In contrast, Dr. Fiore was not board certified in those areas, although he was board certified in the distinct area of internal medicine. Accordingly, under the clear and unambiguous statutory language of *MCL 600.2169*; MSA 27A.2169, Dr. Fiore was not qualified to give expert testimony in this case on behalf of Shenduk. Like any attorney practicing in Michigan, Shenduk's counsel should have been familiar with the well-established principle that clear and unambiguous statutory language is to be applied by a court in accordance with its plain meaning. See, e.g., *Rickner v Frederick, 459 Mich 371, 378; 590 NW2d 288 (1999)* ("if the Legislature has crafted a clear and unambiguous provision, we assume that the plain meaning was intended, and we enforce the statute as written"); *McKenzie v Auto Club Ins Ass'n, 458 Mich 214, 217; 580 NW2d 424 (1998)*, quoting *Tryc v Michigan Veterans' Facility, 451 Mich 129, 135-136;* [*9] *545 NW2d 642 (1996)* ("If the language of a statute is clear and unambiguous, the plain meaning of the statute reflects the legislative intent and judicial construction is not permitted. Further, we are to give statutory language its ordinary and generally accepted meaning."). Thus, the trial court did not clearly err, *Phillips, supra,* in concluding that Shenduk's counsel could not have *reasonably* believed that Dr. Fiore's affidavit complied with the affidavit of merit requirement of *MCL 600.2912d*; MSA 27.2912(4) because Dr. Fiore was plainly not eligible to provide expert testimony in this case under *MCL 600.2169*; MSA 27A.2169.

B. Constitutionality of *MCL 600.2169*; MSA 27A.2169

Shenduk alternatively argues that the trial court erred in dismissing her complaint because *MCL 600.2169*; MSA 27A.2169 is unconstitutional. Shenduk's position is that, by setting greater requirements for the admission of expert testimony in a medical malpractice case than those required by MRE 702 for the admission of expert testimony generally, *MCL 600.2169* [*10] ; MSA 27A.2169 violates Const 1963, art 6, § 5, which provides that the Michigan Supreme Court "shall by general rules establish, modify, amend and simplify the practice and procedure in all courts of this state." However, the Michigan Supreme Court recently decided this precise issue, contrary to Shenduk's position, in *McDougall, supra.* n3 The Court concluded that a statutory rule of evidence that conflicts with a court rule violates Const 1963, art 6, § 5 only if it involves "'no clear legislative policy regarding matters other than judicial dispatch of litigation.'" *McDougall, supra,* slip op at 17-18, quoting *Kirby v Larson, 400 Mich 585, 598; 256 NW2d 400 (1977).* Accordingly, if in a given case a particular court rule conflicts with a statutory rule of evidence based on a policy consideration other than court administration, then the court rule must yield to the statutory provision. *Id.* at 18. Applying these principles, the Court concluded that *MCL 600.2919*; MSA 27A.2169 "reflects wide-ranging and substantial policy considerations relating to medical malpractice actions against specialists, [*11] " and that it does not violate Const 1963, art 6, § 5. *Id.* at 2, 23. Thus, the trial court's dismissal of the complaint at issue should not be disturbed based on this issue.

> n3 A majority of this panel previously entered an order holding the present case in abeyance in anticipation of the Michigan Supreme Court resolving the pertinent issue in *McDougall.* We offer no view on the soundness of our Supreme Court's opinion in *McDougall*, but simply apply it as binding precedent.

IV. No. 200389

Besides repeating the arguments that the trial court erred in dismissing the earlier complaint at issue in No. 199547, which we have already discussed and rejected, Shenduk argues that the trial court erred by granting summary disposition in favor of defendants based on the statute of limitations with regard to the complaint in the later filed action at issue in No. 200389. We disagree.

Shenduk does not dispute that the complaint at issue was not filed until after the running of the statute of limitations, even [*12] with the statute being tolled during the pendency of the prior action that was dismissed without prejudice. Rather, she argues that this Court should recognize the doctrine of equitable tolling in accordance with the out-of-state authority of *Hosogai v Kadota, 145 Ariz 227; 700 P2d 1327, 1333 (1985).* However, even assuming arguendo that this Court should so recognize the doctrine of equitable tolling, one of its basic requirements is that the plaintiff diligently filed the second action. *Id.* In this case, Shenduk has failed to provide, either below or in this Court, any reasonable excuse for her failure to timely file the complaint at issue. n4 In this regard, the policy reasons behind the statutes of limitation include penalizing plaintiffs who are not industrious in pursuing their claims and conversely encouraging plaintiffs to pursue claims diligently. *Lemmerman v Fealk, 449 Mich 56, 65; 534 NW2d 695 (1995).* Accordingly, Shenduk has

not shown that the trial court erred by granting summary disposition in favor of defendants based on the statute of limitations.

> n4 We note that any difficulty that Shenduk *might* perhaps have had in locating a qualified medical professional to provide the affidavit of merit in connection with the complaint at issue did not provide a reasonable excuse for failing to timely file the complaint. The requirement of filing an affidavit of merit in a medical malpractice action that is provided by *MCL 600.2912d(1)*; MSA 27A.2912(4)(1) is expressly made subject to *MCL 600.2912d(2)*; MSA 600.2912(4)(2), which provides:
>
> > Upon motion of a party for good cause shown, the court in which the complaint is filed may grant the plaintiff or, if the plaintiff is represented by an attorney, the plaintiff's attorney an additional 28 days in which to file the affidavit required under subsection (1).
>
> However, Shenduk never sought to avail herself of this provision and accordingly cannot reasonably contend that she was denied an opportunity to timely file a proper affidavit of merit.

[*13]

V. Conclusion

In No. 199547, Shenduk has not established that the trial court clearly erred by dismissing her complaint. Under *McDougall*, *MCL 600.2169*; MSA 27A.2169 is not unconstitutional as violative of Const 1963, art 6, § 5. In No. 200389, Shenduk has not shown that the trial court erred by granting summary disposition in favor of defendants based on the statute of limitations.

Affirmed.

/s/ William C. Whitbeck

/s/ Barbara B. MacKenzie

CONCURBY: William B. Murphy

DISSENTBY: William B. Murphy

DISSENT: MURPHY, J. (concurring and dissenting).

I concur in the majority's analysis of plaintiff's arguments because I am compelled to do so by the recent Supreme Court decision in *McDougall v Schanz, 461 Mich 15; 597 NW2d 148 (1999)*, and adherence to established rules of statutory construction. I write separately, however, to express my view that this produces a nonsensical and likely unjust result under the facts of this case. I dissent from the result reached by the majority because I believe there existed an alternative to the remedy of dismissal imposed by the trial court.

I first note my concerns with the majority analysis in which [*14] I reluctantly concur. Application of the *McDougall* holding in this case effectively requires this Court to acquiesce in closing the door of the courthouse to a seriously injured party because the party's proffered expert witness, who from the record appears highly qualified, does not possess the same credentials as that of the treating physician. This outcome is mandated by *McDougall*, even though a different result would obtain under judicially established rules of evidence relating to qualification and admissibility of expert witness testimony. MRE 702. n1 Unlike the majority in this case, I do respectfully question the *McDougall* decision because of its impact on the judiciary's constitutional authority to govern trials by determining rules of practice and procedure. By applying the *McDougall* holding in this case, we may well be witnessing an injustice by giving superiority to an act of the Legislature that runs contrary to a judicially created rule of evidence promulgated under the authority of the Michigan Constitution. n2

> n1 MRE 702 provides:
>
> > If the court determines that recognized scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education, may testify thereto in the form of an opinion or otherwise.

[*15]

> n2 "The Supreme Court shall by general rules establish, modify, amend and simplify the practice and procedures in all courts of this state . . . ." (Const 1963, art 6, § 5.)

In this case, as the majority concisely explains, however, well-established principles of statutory interpretation mandate the conclusion that plaintiff's attorney could not have "reasonably believed," under *MCL 600.2912d(1)*; MSA 27A.2912(4)(1), that Dr. Fiore met the requirements for an expert witness pursuant to *MCL 600.2169*; MSA 27A.2169. My concern is that in this

case these principles restrict our ability to afford a more logical construction to the expert witness statute we are now compelled to apply. As indicated, application of this expert witness statute is compelled by the Supreme Court's recent decision holding the statute constitutional. *McDougall, supra.*

MCL 600.2169; MSA 27A.2169 was enacted because the Legislature was dissatisfied with the manner in which some trial courts, in the medical malpractice arena, [*16] exercised their discretion regarding expert witnesses under MRE 702. See n 3, *post.* Despite the ability of appellate courts to check the inappropriate exercise of this discretionary power, the Legislature instead removed all discretion. In determining that this restrictive statute takes precedence over MRE 702, the Supreme Court has severely hampered our ability to provide justice. This case is especially illustrative of the negative effect of the Supreme Court's decision as a doctor who would unquestionably qualify as an expert witness under MRE 702 is, by operation of *MCL 600.2169*; MSA 27A.2169, excluded from participation in this case. Moreover, by operation of *MCL 600.2912d(1)*; MSA 27A.2912(4)(1), which incorporates the expert witness statute, the courtroom door has in fact been slammed shut in the face of this plaintiff.

I agree with Justice Cavanagh's concern, *McDougall, supra at 58-63,* regarding that majority's determination that rules implicating considerations of "judicial dispatch," and nothing more, remain the only rules as to which the judiciary may exercise its constitutional grant of supremacy. [*17] In exercising control over previous medical malpractice actions courts could flexibly employ MRE 702 to weed out claims with no legal merit. In applying this rule courts undoubtedly, and appropriately, considered factors other than efficiency and judicial dispatch. Because more than efficiency was at issue, however, the Supreme Court has removed that flexibility. The result in this case follows, and I am not convinced that the negation of the judiciary's constitutional authority to control this aspect of trial proceedings was appropriate. Handcuffed as we are, what appears to be a meritorious claim is foreclosed by the operation of statutes enacted with the primary intent of screening out frivolous actions.

As a threshold to initiating a medical malpractice action, pursuant to *MCL 600.2912d(1)*; MSA 27A.2912(4)(1) the complainant must also file an affidavit of merit. This statute establishes the requirements of the affidavit, providing in pertinent part:

> . . . the plaintiff in an action alleging medical malpractice or, if the plaintiff is represented by an attorney, the plaintiff's attorney shall file with the complaint an affidavit of merit signed by [*18] a health professional who the plaintiff's attorney reasonably believes meets the requirements for an expert witness under section 2169. The affidavit of merit shall certify that the health professional has reviewed the notice and all medical records supplied to him or her by the plaintiff's attorney concerning the allegations contained in the notice and shall contain a statement of each of the following:
>
> (a) The applicable standard of practice or care.
>
> (b) The health professional's opinion that the applicable standard of practice or care was breached by the health professional or health facility receiving the notice.
>
> (c) The actions that should have been taken or omitted by the health professional or health facility in order to have complied with the applicable standard of practice or care.
>
> (d) The manner in which the breach of the standard of practice or care was the proximate cause of the injury alleged in the notice.

The only issue of contention regarding the adequacy of this plaintiff's affidavit concerns whether plaintiff's attorney *reasonably believed* that the signatory of the affidavit qualified as an expert witness under *MCL 600.2169* [*19] ; MSA 27A.2169, which in turn provides in pertinent part:

> (1) In an action alleging medical malpractice, a person shall not give expert testimony on the appropriate standard of practice or care unless the person is licensed as a health professional in this state or another state and meets the following criteria:
>
> (a) If the party against whom or on whose behalf the testimony is offered is a specialist, specializes at the time of the occurrence that is the basis for the action in the same specialty as the party against whom or on whose behalf the testimony is offered. However, if the party against whom or on whose behalf the testimony is offered is a specialist who is board certified, the expert witness must be a specialist who is board certified in that specialty.
>
> * * *
>
> (2) In determining the qualifications of an expert witness in an action alleging medical

> malpractice, the court shall, at a minimum, evaluate all of the following:
>
> (a) The educational and professional training of the expert witness.
>
> (b) The area of specialization of the expert witness.
>
> (c) The length of time the expert witness has been engaged in the active clinical practice or instruction of the health profession [*20] or the specialty.
>
> (d) The relevancy of the expert witness's testimony.

In this case, the evidence is undisputed that defendant Dr. Talbert was board certified in general surgery and in thoracic surgery with a specialty in cardiothoracic surgery. It is further undisputed that plaintiff's proffered expert, Dr. Louis Fiore, was board certified in internal medicine and in the subspecialty of medical oncology and the subspecialty of hematology. As drafted, the statute clearly requires that when a defendant has board certification in a particular specialty an expert witness must hold matching board certification. Thus the majority's finding, that "under the clear and unambiguous statutory language of *MCL 600.2169*; MSA 27A.2169, Dr. Fiore was not qualified to give expert testimony in this case," is the only permissible conclusion. I nevertheless sympathize with plaintiff's argument that by such operation the statute can, and in this case has, worked a nonsensical result.

Plaintiff's contention is that the statute is arguably ambiguous to the extent that it does not provide for every possible scenario of alleged medical malpractice. Specifically, in this case [*21] plaintiff argues that Dr. Talbert was acting outside the scope of his specialty when the alleged malpractice occurred. Plaintiff argues that because the expertise of the specialty may be demonstratively irrelevant to such a claim, we should find that it could not have been the Legislature's intent to require a matching specialist under such circumstances. Thus, plaintiff argues, we should find credible the contention that it was *reasonably believed* that despite not satisfying *MCL 600.2169*; MSA 27A.2169 Dr. Fiore would qualify as an expert sufficient for the purpose of filing the affidavit of merit.

Given the preliminary facts supporting this claim, plaintiff's argument is compelling. Plaintiff alleges that Dr. Talbert's malpractice occurred during post-operative treatment with heparin, contending that treatment with this drug is generic to all medical fields and is not distinct within the cardiothoracic specialty. Dr. Fiore's curriculum vitae unquestionably demonstrates that he is an expert on the issue of heparin treatment. Assuming that plaintiff's theory could be established at trial, the argument that Dr. Fiore's testimony would be of significant [*22] help to the jury is well founded. As the statute reads on its face, however, Dr. Fiore's lack of knowledge regarding the allegedly irrelevant field of cardiothoracic surgery prevents the jury from hearing his highly relevant testimony on the critical issue.

The requirement of matching specialties may make sense in the context of alleged malpractice within the scope of the specialty as it limits testimonial privileges to those doctors with equivalent knowledge of and experience in the subject area. n3 If a doctor commits malpractice while acting outside the scope of his specialty, however, the statutory requirement operates to limit testimony to that of a doctor potentially as unqualified as the defendant in the area of practice at issue, a result blatantly counterintuitive. n4 On its face the statute wholly fails to provide for such a scenario, suggesting no avenue by which parties can ensure that under such circumstances the best expert testifies. As a consequence today's conclusion results.

n3 See *Report of the Senate Select Committee on Civil Justice Reform*, issued September 26, 1995 (emphasis added), stating in pertinent part:

> As a practical matter, in many courts merely a license to practice medicine is needed to become a medical expert on an issue.
>
> This has given rise to a group of national professional witnesses who travel the country routinely testifying for plaintiffs in malpractice actions. These "hired guns" advertise extensively in professional journals and compete fiercely with each other for the expert witness business. For many, testifying is a full-time occupation and they rarely actually engage in the practice of medicine. There is a perception that these so-called expert witnesses will testify to whatever someone pays them to testify about.
>
> *This proposal is designed to make sure that expert witnesses actually practice or teach medicine. In other words, to make sure that experts will have firsthand practical expertise in the subject matter about which they are testifying.* In particular, with the mal-

> practice crisis facing high-risk specialists, such as neurosurgeons, orthopedic surgeons and ob/gyns, this reform is necessary to insure that in malpractice suits against specialists the expert witnesses actually practice in the same specialty. This will protect the integrity of our judicial system by requiring real experts instead of "hired guns."

[*23]

> n4 See *McDougall, supra,* Cavanagh, J. dissenting, at 67, (anticipating precisely the scenario now faced and concluding that under such circumstances the statute frustrates its purpose).

As we are compelled to so enforce the matching specialist requirement, a major intent of the statute is effectively eviscerated. I cannot, however, reconcile my reservations about the statute with a legal analysis that would permit the result plaintiff prays we reach. There simply is none. The language of the statute is clear and unambiguous - plaintiff's suggestion notwithstanding - and we must therefore apply its plain meaning. See *Rickner v Frederick, 459 Mich 371, 378; 590 NW2d 288 (1999).* That it is apparent that the Legislature made no provision for circumstances such as these, unfortunately does not change our duty. In fact, it is arguable that our adherence to the "plain meaning" principle is further mandated by the history of the statute. The statutory language we now consider is that of the 1993 version of the statute. Prior to this most recent amendment [*24] the pertinent language of the 1986 version read:

> (1) In an action alleging medical malpractice, if the defendant is a specialist, a person shall not give expert testimony on the appropriate standard of care unless the person is or was a physician licensed to practice medicine or osteopathic medicine and surgery or a dentist licensed to practice dentistry in this or another state and meets both of the following criteria:
>
> (a) Specializes, or specialized at the time of the occurrence which is the basis for the action, in the same specialty *or a related, relevant area of medicine* or osteopathic medicine and surgery or dentistry as the specialist who is the defendant in the medical malpractice action. [Emphasis added.]

"A change in statutory language is presumed to reflect a change in the meaning of the statute." *Eaton Farm Bureau v Eaton Township, 221 Mich App 663, 668; 561 NW2d 884 (1997).* Thus, the increased restriction of the current 1993 version, not allowing for specialists of a *related* discipline, indicates that strict adherence is intended.

Despite my inability to interpret these statutes in accord with plaintiff's argument, [*25] I would nevertheless reverse the trial court's dismissal in Docket No. 199547. In *VandenBerg v VandenBerg, 231 Mich App 497, 502; 586 NW2d 570 (1998),* where the plaintiff failed to file an affidavit of merit at the time she filed the complaint, this Court concluded that *MCL 600.2912d*; MSA 27A.2912(4) does not mandate dismissal for noncompliance. n5 Noting that the trial court in that case did not consider any other sanction for the plaintiff's noncompliance, this Court determined that the purpose of deterring frivolous suits was fulfilled because the defendants received service of the appropriate affidavit of merit at the same time as they received service of the complaint. *Id.* at 502-503. Although, as concluded under the mandated interpretation of the statutes, this plaintiff's timely affidavit of merit was *technically* inappropriate, I believe that this affidavit similarly satisfied the statutory purpose.

> n5 Cf. *Scarsella v Pollak, 232 Mich App 61; 591 NW2d 257 (1998),* in which a separate panel of this Court reached the opposite conclusion where the plaintiff filed his affidavit of merit only after the statute of limitations had run. Although the *Scarsella* panel explicitly distinguished *VandenBerg* in a footnote, the analyses in the bodies of these two opinions appear contradictory.

[*26]

From the record, it appears that the trial court's review of plaintiff's affidavit of merit was cursory at best. Noting only that the two doctors' specialties did not match, and dismissing the action on that basis, the court refused to consider plaintiff's contention that the affidavit supported the meritorious nature of the claim of malpractice related to the hematological aspects of plaintiff's treatment. As discussed, I believe plaintiff's argument has merit. I further believe that close examination of the affidavit and Dr. Fiore's credentials supports that argument. I would find that in failing to fully consider the affidavit, and by contemplating no remedy other than dismissal, the trial court's review did not serve the purpose of the statute.

Dismissal not mandated by the statute, the trial court could have entered an alternative order. In the most obvious possibility, reflective of the remedy provided by *MCL*

600.2912d(2); MSA 27A.2912(4)(2), the court could have required plaintiff to refile a compliant affidavit within twenty-eight days. Though it may be argued that dismissal without prejudice did not wholly foreclose plaintiff's action - the trial [*27] court did acknowledge plaintiff's ability to refile the entire complaint - I do not believe that these alternative orders are practically equivalent. An order requiring plaintiff to secure a new affidavit in twenty-eight days would unquestionably have demanded less to sustain the claim than plaintiff was forced to do under the dismissal order. As indicated by the majority in its discussion of Docket No. 200389, for whatever the reason plaintiff was unable to refile the papers necessary to reinitiate her action, of which a new affidavit was but one item, within the time remaining under the statute of limitations. Had the court better evaluated the merit of plaintiff's claim, in light of the relevant though technically inappropriate affidavit, a more specific order requiring mere correction of the technical failing would perhaps have resulted in the maintenance of this non-frivolous action. Given the failure to consider alternative remedies, I would reverse on a finding that imposition of the harsh sanction of dismissal was inappropriate. *Id.* at 503.

As the majority has affirmed the trial court, however, I would respectfully urge the Supreme Court to utilize this case as a vehicle [*28] to reconsider its ruling in *McDougall* and its attendant ramifications. As my comments above indicate, deference to the Legislature should not come at the expense of the judiciary's constitutional responsibility to provide for and protect the practice and procedures established to assure that justice occurs.

/s/ William B. Murphy

LEXSEE 2003 MICH APP LEXIS 2647

JOHANNA WOODARD, Individually and as Next Friend of AUSTIN D. WOODARD, a Minor, and STEVEN WOODARD, Plaintiffs-Appellants, v JOSEPH R. CUSTER, M.D., Defendant-Appellee, and MICHAEL K. LIPSCOMB, M.D., MICHELLE M. NYPAVER, M.D., and MONA M. RISKALLA, M.D., Defendants. JOHANNA WOODARD, Individually and as Next Friend of AUSTIN D. WOODARD, a Minor, and STEVEN WOODARD, Plaintiffs-Appellants, v UNIVERSITY OF MICHIGAN MEDICAL CENTER, Defendant-Appellee.

No. 239868, No. 239869

COURT OF APPEALS OF MICHIGAN

2003 Mich. App. LEXIS 2647

October 21, 2003, Decided

NOTICE: [*1] THIS IS AN UNPUBLISHED OPINION. IN ACCORDANCE WITH MICHIGAN COURT OF APPEALS RULES, UNPUBLISHED OPINIONS ARE NOT PRECEDENTIALLY BINDING UNDER THE RULES OF STARE DECISIS.

SUBSEQUENT HISTORY: Later proceeding at *Woodard v. Custer, 471 Mich. 890, 687 N.W.2d 298, 2004 Mich. LEXIS 1902 (2004)*
Appeal granted by *Woodard v. Custer, 2005 Mich. LEXIS 1105* (Mich., July 12, 2005)
Reversed by, in part *Woodard v. Custer, 2005 Mich. LEXIS 1107* (Mich., July 12, 2005)

PRIOR HISTORY: Washtenaw Circuit Court Court of Claims. LC No. 99-005364-NH. LC No. 99-017432-CM. *Woodward v. Custer, 2003 Mich. App. LEXIS 2619* (Mich. Ct. App., Oct. 21, 2003)

JUDGES: Before: Meter, P.J., and Talbot and Borrello, JJ. BORRELLO, J., (dissenting). METER, J., (concurring in part and dissenting in part.)

OPINION: PER CURIAM.

In these consolidated medical malpractice cases against the physicians and the hospital who treated plaintiffs' infant son, plaintiffs appeal as of right from the trial court's order dismissing their medical malpractice claims with prejudice.

I. Facts and Procedural History

On January 30, 1997, plaintiffs' fifteen-day old infant son, Austin, was diagnosed with retrosyncytial virus bronchiolitis, a life-threatening respiratory disease that attacks infants, necessitating critical care treatment at the University of Michigan Medical Center's Pediatric Intensive Care Unit ("PICU") until February 10, 1997. The medical treatment included muscle relaxants and strong sedatives, mechanical ventilation and intubation, a feeding tube, and the placement of an arterial line in the femoral [*2] vein of the infant's right leg and a venous catheter inserted in the infant's left leg.

By February 10, 1997, the infant had made sufficient recovery that he was weaned from the sedatives and muscle relaxants. However, when he was moved from the intensive care unit to the general hospital ward, he became very agitated and he continuously cried. His left leg was purple in color and swollen as a result of the removal of the venous catheter from his left leg. An x-ray confirmed that deep vein thrombosis had developed in the left leg, a secondary condition to the venous catheter insertion. The x-ray also showed a fracture at the lower end of the femur in the infant's left leg. A subsequent skeletal survey revealed a fracture in the right leg, as well. The Medical Center's consultants were unable to determine the cause of the fractures.

In Docket No. 239868, plaintiffs filed suit against Dr. Joseph Custer, Director of the University of Michigan Medical Center's Pediatric Critical Care Medicine and the physicians who treated their son at the PICU. Plaintiffs raised claims of medical malpractice and negligent infliction of emotional distress. In Docket No. 239869, plaintiffs filed suit [*3] against the University of Michigan Medical Center, raising the same claims.

Dr. Custer and the other defendant physicians responded to the complaint in Docket No. 239868, by moving for summary disposition pursuant to *MCR 2.116(4)* (court lacks jurisdiction over subject matter), *MCR 2.116(5)* (lack of capacity to file suit in absence of an

affidavit of merit), or *MCR 2.116 (7)* (the claim is barred for statutory reasons in the absence of an affidavit of merit). Dr. Custer and defendant physicians asserted that plaintiffs' affidavit of merit was untimely filed and that plaintiffs' medical expert, Anthony Casamassima, was not a qualified expert pursuant to *MCL 600.2169*, because he was not specialized in pediatric critical care or pediatric emergency medicine specialties as were Dr. Custer and defendant physicians.

At the time the trial court heard oral arguments for the motion, the two cases had been consolidated below. The court determined that the affidavit of merit signed by Dr. Casamassima was sufficient for the case to proceed but expressly stated on the record that it was not ruling on whether Dr. Casamassima was a qualified medical expert for purposes [*4] of trial testimony. The court informed defendants that they would be allowed to subsequently challenge Dr. Casamassima's qualifications as an expert witness.

All defendant physicians who treated the infant at the PICU were dismissed from the action by stipulation, leaving Dr. Custer and the Medical Center as the two remaining defendants in this case. After the two defendants deposed Dr. Casamassima, defendants filed four different motions. The Medical Center filed a motion for summary disposition pursuant to *MCR 2.116(C)(10)*, arguing that the testimony of plaintiffs' expert witness failed to support several claims against it because Dr. Casamassima did not provide the applicable standard of care and evidence of a breach of that standard. Dr. Custer filed a motion for summary disposition under *MCR 2.116(C)(10)*, on the ground that plaintiffs cannot bring suit against him under a negligent supervision or respondeat superior theory. Both defendants jointly moved for partial summary disposition pursuant to *MCR 2.116(C)(10)*, on the ground that plaintiffs' deposition testimony failed to support the claims of negligent infliction of emotional distress. Finally, both defendants jointly moved [*5] to strike Dr. Casamassima as an unqualified medical expert and to dismiss the case. In response to the above motions, plaintiffs asserted that the doctrine of res ipsa loquitur would allow an inference of negligence from the facts in this case. Specifically, plaintiffs argued that there was no need for an expert witness because an inference of negligence may be inferred from the fact that the infant was admitted to the PICU with healthy legs only to leave the PICU with fractured legs.

At the hearing for the above motions, defendants' counsel stated that the issue of the applicability of the doctrine of res ipsa loquitur should be reserved for an evidentiary hearing at a later date. Also at the hearing, plaintiffs agreed to dismiss the claims for negligent infliction of emotional distress. Following oral arguments, the trial court granted defendants' motion to strike plaintiffs' expert witness, ruling that Dr. Casamassima was not qualified as a medical expert under *MCL 600.2169*.

The scope of the trial court's decision at the hearing is unclear from the record and we cannot discern whether the court granted defendants summary disposition. Defendants appeared [*6] to have understood that the court did because they attempted to enter an order of dismissal. In response, plaintiffs objected to the entry of the order and they filed a motion for leave to file an amended complaint to assert negligence under the doctrine of res ipsa loquitur. Plaintiffs also filed a motion for a determination whether expert testimony was required in this case or, in the alternative, for leave to substitute their expert witness. In a written opinion and order following oral arguments, the court determined that the elements of the doctrine of res ipsa loquitur were not satisfied, that expert testimony was necessary because negligence could not be inferred from the facts, and that plaintiffs' request to substitute their expert was untimely. Accordingly, the court dismissed plaintiffs' case with prejudice, reasoning that without expert testimony plaintiffs could not prove their medical malpractice claims.

II. Standard of Review

It is unclear from the above-mentioned procedural history and from the written opinion and order dismissing the case whether the trial court determined the matter under defendants' motions for summary disposition pursuant to *MCR 2.116(C)(10)*, [*7] or as a result of an evidentiary hearing in which the court ruled to dismiss the case because plaintiffs failed to support their claims. The former would be reviewed under a de novo standard, *Spiek v Dep't of Transportation, 456 Mich. 331, 337; 572 N.W.2d 201 (1998)*, while the latter would be under an abuse of discretion standard. See *Vicencio v Ramirez, 211 Mich. App. 501, 506; 536 N.W.2d 280 (1995); Zantop Int'l Airlines, Inc v Eastern Airlines, 200 Mich. App. 344, 359; 503 N.W.2d 915 (1993)*.

The procedural history in this case indicates that plaintiffs' motion to amend its complaint to add the doctrine of res ipsa loquitur was unnecessary. Plaintiffs were not attempting to add new claims but only to assert the manner in which they were to prove their original claims. The doctrine was first raised in plaintiffs' response to the motions for summary disposition and it is unclear why it was not addressed at the hearing for the summary disposition motions when the necessary deposition testimony upon which plaintiffs relied was already before the trial court. The fact that the court did not address [*8] this argument at the hearing would suggest that it was obliged to do so as a continuation of its ruling on summary disposition. It is apparent that plaintiffs filed the motion to amend their

complaint in an effort to salvage the case from premature dismissal. Accordingly, the court's ruling was determined as part of the continuation of the hearing on defendants' motions for summary disposition.

Summary disposition is appropriate when there is no genuine issue of material fact and the moving party is entitled to judgment as a matter of law. *Auto-Owners Ins Co v Allied Adjusters & Appraisers, Inc, 238 Mich. App. 394, 397; 605 N.W.2d 685 (1999).* In reviewing motions for summary disposition brought under *MCR 2.116(C)(10)*, this Court considers the pleadings, affidavits, depositions, and other documentary evidence submitted by the parties in the light most favorable to the party opposing the motion. *Tate v Detroit Receiving Hosp, 249 Mich. App. 212, 215; 642 N.W.2d 346 (2002).* Whether a witness is qualified to render an expert opinion and the actual admissibility of the expert's testimony are within the trial court's discretion [*9] and such determinations are reviewed on appeal for an abuse of discretion. *Id.* In civil cases, an abuse of discretion is found only in extreme cases in which the result is so palpably and grossly violative of fact and logic that it evidences a perversity of will, a defiance of judgment, or the exercise of passion or bias. *Dep't of Transportation v Randolph, 461 Mich. 757, 768; 610 N.W.2d 893 (2000).*

III. Analysis

A. Medical Expert Witness Qualifications

Plaintiffs argue that the trial court abused its discretion in determining that Dr. Casamassima was an unqualified medical expert. Specifically, plaintiffs claim that their theory of the case is not grounded in pediatric critical care but in general pediatric medicine, and that both Dr. Casamassima and Dr. Custer were board certified in pediatric medicine. Plaintiffs also assert that Dr. Custer's specialization in pediatric critical care was a "subspecialty" which Dr. Casamassima was not required to possess under *MCL 600.2169.*

In pertinent part, *MCL 600.2169* provides:

> (1) In an action alleging medical malpractice, a person shall not give [*10] expert testimony on the appropriate standard of practice or care unless the person is licensed as a health professional in this state or another state and meets the following criteria:
>
> (a) If the party against whom or on whose behalf the testimony is offered is a specialist, specializes at the time of the occurrence that is the basis for the action in the same specialty as the party against whom or on whose behalf the testimony is offered. *However, if the party against whom or on whose behalf the testimony is offered is a specialist who is board certified, the expert witness must be a specialist who is board certified in that specialty.* [Emphasis added.]

Plaintiffs claim that the basis for the action is not grounded in pediatric critical care but in general pediatric medicine because the fractures were caused by "the manner in which the infant was handled and maneuvered" at the PICU. However, as further discussed in the second issue in this opinion, plaintiffs were unable to establish that the fractures were caused by the manner in which the infant was "handled and maneuvered" at the PICU. It was disputed whether the fractures occurred during the infant's stay [*11] at the PICU and whether the injuries resulted from a pathological cause or child abuse. Accordingly, plaintiff's claim that the fractures were caused by the mere "handling and maneuvering" of the infant during its stay at the PICU is without merit. n1

> n1 Plaintiffs argue that defendants failed to present evidence showing that the manner in which an infant should be "handled and maneuvered" is "unique" to critical care. However, it is the *plaintiff's* burden of proof to show the standard of care in a medical malpractice case. *Locke v Pachtman, 446 Mich. 216, 222; 521 N.W.2d 786 (1994).*

Moreover, plaintiffs have not established that the medical standard of care for an inpatient intensive care unit for critically ill infants is the same as that for general pediatric medicine. It appears from the record that it is not. Plaintiffs' own expert witness, Dr. Casamassima, testified that a number of procedures that were performed on the infant at the PICU had the potential to cause fractures [*12] to the legs. He did not assert that those procedures were normally practiced in general pediatrics or that the standard of care for the treatment of critically ill infants was the same as that for general pediatric practice. Rather, he opined that the standard of care for the PICU was grounded in the policies and procedures established for those medical procedures - but he expressly testified that he did not know what the policies and procedures were. Accordingly, plaintiffs' theory of the case was grounded not in general pediatric treatment but in pediatric intensive care.

Because the basis of the action is grounded in pediatric intensive care, plaintiffs were mandated by § 2169(1)(a) to present an expert who possessed that specialization. Dr. Casamassima's clinical practice during the year immediately preceding the instant injury, § 2169(1)(b), did not involve pediatric critical care medicine. Given that Dr.

Casamassima acknowledged that he was unaware of the precise standard of care for the treatment of critically ill infants, it is clear that plaintiffs were required to present an expert witness who was.

Plaintiffs rely on this Court's decision in *Tate, supra,* [*13] and argue that § 2169(1)(a) does not require Dr. Casamassima to possess the same "subspecialties" of pediatric critical care medicine and pediatric intensive care that Dr. Custer possessed. Plaintiffs misread the decision in *Tate*, which held:

> Thus, where a defendant physician has several board certifications and the alleged malpractice involves only one of these specialties, § 2169 requires an expert
>
> witness to possess the same specialty as that engaged in by the defendant physician during the course of the alleged malpractice. [*Tate, supra at 220.]*

Dr. Casamassima's testimony in this case was offered against Dr. Custer. It is undisputed that Dr. Custer was board certified in three specialty areas: pediatrics, pediatric critical care medicine, and neonatology-perinatology. Plaintiffs have provided nothing to establish that any of the three certifications was a "subspecialty." The decision in *Tate* mandates that, because plaintiffs' claims rested in the area of pediatric critical care medicine and because Dr. Custer was board certified in pediatric critical care medicine, plaintiffs' expert was required to posses that specialty. [*14] Insofar as the trial court determined that Dr. Casamassima was required to possess the same subspecialties as Dr. Custer and the physicians who treated the infant at the PICU, such ruling was erroneous, but harmless. Therefore, the trial court did not abuse its discretion when it determined that Dr. Casamassima did not meet the qualifications requirements set forth in § 2169(1)(a), because he did not possess board certification in pediatric critical care medicine.

B. Exceptions to Expert Witness Testimony

Plaintiffs next argue that the trial court erred in determining that the doctrine of res ipsa loquitur was inapplicable in this case.

To prove a medical malpractice claim, a plaintiff must establish the following four factors: (1) the applicable standard of care, (2) breach of that standard of care by the defendant, (3) injury, and (4) proximate causation between the alleged breach and the injury. *Locke v Pachtman, 446 Mich. 216, 222; 521 N.W.2d 786 (1994).* "In an action alleging medical malpractice, the plaintiff has the burden of proving that he or she suffered an injury that more probably than not was proximately caused by the negligence of the [*15] defendant or defendants." *MCL 600.2912a(2).* Expert testimony is required in medical malpractice cases to establish the applicable standard of care and to demonstrate that the defendant somehow breached that standard. *Birmingham v Vance, 204 Mich. App. 418, 421; 516 N.W.2d 95 (1994).* However, "while expert testimony is the traditional and the preferred method of proving medical malpractice, exceptions to the need for expert testimony have been recognized" and one such exception is when a plaintiff's case satisfies the doctrine of res ipsa loquitur. *Locke, supra at 230.* Where the elements of the doctrine are satisfied, negligence can be inferred. *Thomas v McPherson Community Health Center, 155 Mich. App. 700, 705; 400 N.W.2d 629 (1986).* The following four factors are necessary to a res ipsa loquitur claim:

> (1) the event must be of a kind which ordinarily does not occur in the absence of someone's negligence;
>
> (2) it must be caused by an agency or instrumentality within the exclusive control of the defendant;
>
> (3) it must not have been due to any voluntary [*16] action or contribution on the part of the plaintiff. . . .
>
> [4] "evidence of the true explanation of the event must be more readily accessible to the defendant than to the plaintiff." [*Locke, supra,* quoting *Jones v Porretta, 428 Mich. 132, 150-151; 405 N.W.2d 863 (1987).]*

As to the first factor, "the fact that the injury complained of does not ordinarily occur in the absence of negligence must either be supported by expert testimony or must be within the common understanding of the jury." *Locke, supra at 231.*

The trial court determined that expert testimony was required in this case in order to address whether the fractures could have occurred in the absence of negligence and to rule out the possibility that the fractures were caused as risks arising from the types of procedures performed at the PICU. It is unfortunate that the cause of the fractures or an exact timeframe in which the fractures occurred

were never determined in this case, particularly because it appears that Austin may face extensive medical treatment due to the resulting difference in the length of his legs. However, as the court [*17] concluded, plaintiffs' case cannot proceed without expert testimony which was necessary to establish that defendants actually caused an injury for purposes of the medical malpractice claim.

First, and contrary to plaintiffs' contention on appeal, it is disputed whether the fractures occurred during the infant's stay at the PICU. Plaintiffs rely on the deposition testimony of three adverse witnesses: in addition to Dr. Custer's testimony, plaintiffs rely on the testimony of Dr. Randall Loder, an orthopedic surgeon at the Medical Center, and Dr. Clyde Owings, the medical director of the Child Protection Team at the Medical Center, both of whom investigated the causes of the fractures at the time the fractures were discovered.

Dr. Loder opined that the fractures were inflicted. He concluded that the bone growth surrounding the fractures indicated that the fracture in the left leg occurred within seven days of the February 11, 1997, x-ray. This would place the injury during the infant's stay at the PICU. Dr. Loder also concluded that the fracture in the right leg occurred between fourteen to twenty-one days of the February 13, 1997 skeletal survey. This would place the injury's occurrence [*18] on the first day the infant was admitted to the PICU or any time during the preceding week or so. On the other hand, Dr. Owings concluded that the right leg was not fractured. Instead, he determined that the infant suffered from periosteal stripping in the right leg that can be pathologically caused in fifteen to thirty percent of the cases, and he doubted whether Dr. Loder was professionally capable of diagnosing this disease that was unrelated to the treatment of bones. Importantly, Dr. Owings opined that determining the age of fractures was similar to that of appraising art, and he did not rule out the possibility that the fracture in the left leg could have been caused at the time of the infant's birth.

Although Dr. Custer did not dispute the existence of the fractures, he never determined when the fractures occurred. Similar to Dr. Owings' determination, Dr. Custer did not rule out the possibility that the infant already had the fractures when he was admitted to hospital. Dr. Custer, who examined the infant upon admission, explained that he had personally missed diagnosing this specific type of fracture in the physical examination of infants and that a skeletal survey was the [*19] method used in such diagnosis. Dr. Loder supported the above testimony by explaining that it was difficult to discover this type of fracture through a physical examination because some infants simply do not cry to notify the examiner of anything that may be wrong. Dr. Owings also explained that the pain reaction of infants is considerably different than that of adults, and bone fractures of this sort were difficult to discover in an infant. Thus, even viewed in the light most favorable to plaintiffs, the testimony upon which they rely does not rule out the possibility that the fractures may have occurred before the infant was admitted to the hospital.

Second, the possibility of a pathological cause for the fractures was never ruled out by the witnesses upon whose testimony plaintiffs rely. While Dr. Custer testified that he could rule out the possibility of brittle bone disease from the record before him at the time of his deposition, he did not render an opinion with respect to any other type of pathological cause for the fractures. Dr. Owings discovered from his physical examination of the infant common forms of osteogenisis imperfecta, or brittle bone disease, but he left the proper [*20] diagnosis to the experts in the field. The record indicates that an expert in the field, a Dr. Innis, had examined the infant but it does not appear that he was deposed in this case. Dr. Loder agreed that Dr. Innis' examination of the infant at the time the fractures were discovered revealed no evidence of osteogenisis imperfecta, but he also added that osteogenisis imperfecta constituted a clinical diagnosis requiring the monitoring of the infant's growth. On this record, there is nothing to show that osteogenisis imperfecta or any other pathological cause were medically ruled out.

Third, and contrary to plaintiffs' assertion on appeal, an intentional injury under child abuse was also not ruled out in this case. Both Dr. Custer and Dr. Loder never formulated an opinion whether the fractures were caused as a result of child abuse. On the other hand, Dr. Owings did not find evidence sufficient to make a report for Child Protective Services, but he did not rule out the possibility of child abuse. It must be noted here that Dr. Owings also testified that, out of the hundreds of cases that he had investigated, this was the only one in which he had no record of his investigation. However, [*21] because Dr. Owings did not rule out child abuse as a cause for the fractures, plaintiffs' claim that child abuse was ruled out in this case is without merit.

Thus, given that plaintiffs failed to prove that the fractures actually occurred during the infant's stay at the PICU, plaintiffs have failed to show that defendants caused the injuries or that the injuries were of a kind that ordinarily do not occur in the absence of someone's negligence to satisfy the first factor for the doctrine of res ipsa loquitur.

Plaintiffs also failed to show that the fractures were caused by an agency or instrumentality within the exclusive control of defendants to satisfy the second factor for the doctrine of res ipsa loquitur. Even assuming that the

fractures occurred during the infant's stay at the PICU, the proofs established that persons other than medical staff had access to the infant, including his parents, grandmother, and the parent of the child with whom the infant shared a hospital room.

Because the fractures could have occurred before the infant's hospitalization and because plaintiffs had access to the infant during his stay at the PICU, plaintiffs also failed to satisfy the third factor, [*22] which provides that the injuries must not have been caused by any voluntary action or contribution on the part of plaintiffs. As to the fourth factor, the results of the Medical Center's extensive medical investigation into the matter, involving experts from at least three different medical fields, was inconclusive. From this record, it cannot be said that the evidence of the true explanation of the event was more readily accessible to defendants than to plaintiffs to satisfy the fourth factor. Therefore, the elements of the doctrine of res ipsa loquitur were not met in this case.

Plaintiffs next argue that an expert witness was not required because the alleged negligence was "a matter of common knowledge and observation." Expert testimony may not be required when "the lack of professional care is so manifest that it would be within the common knowledge and experience of the ordinary layman that the conduct was careless and not conformable to the standards of professional practice and care . . . ." *Locke, supra at 232.*

Assuming that the injuries were sustained during the infant's stay at the PICU, there is nothing whatsoever on this record to indicate that the fractures [*23] were caused by the manner in which the infant was handled and maneuvered, as plaintiffs claim. Therefore, any inference of malpractice must derive from the treatment that the infant received. Such treatment included muscle relaxants and strong sedatives, mechanical ventilation and intubation, a feeding tube, and the placement of an arterial line in the femoral vein of the infant's right leg and a venous catheter inserted in the infant's left leg. Accordingly, the trial court did not err in finding that the procedures the infant underwent were not within the common knowledge of a reasonably prudent factfinder. Assuming that the fractures may have been caused by the placement of the lines in the infant's legs, the risks associated with the placement of arterial lines or venous catheters in a newborn infant, and whether fractures ordinarily do not occur in the absence of negligence, are not within common knowledge of a reasonably prudent fact finder.

Plaintiffs' reliance on the decisions in *Sullivan v Russell, 417 Mich. 398; 338 N.W.2d 181 (1983),* and *Higdon v Carlebach, 348 Mich. 363; 83 N.W.2d 296 (1957)* is misplaced. In those [*24] cases, healthy and undiseased parts of the body requiring no treatment were injured. It appears that plaintiffs assume that the fractures were caused by the placement of the arterial line and venous catheter in the infant's legs. However, the infant's mother testified that the placements were made because the physicians could not locate the relevant veins in the infant's head. Plaintiffs do not dispute that such procedure was necessary for treating the life-threatening respiratory disease with which the infant was diagnosed. While the legs may have required no treatment, their use was necessary for the treatment of the diseased parts of the infant's body. Thus, the trial court properly ruled that the medical practice in this case was not a matter of common knowledge.

/s/ Michael J. Talbot

CONCURBY: Patrick M. Meter

CONCUR: METER, J. (*concurring in part and dissenting in part.*)

I concur with Judge Talbot's analysis of the expert witness issue. I concur with Judge Borrello's analysis of the res ipsa loquitur issue. I find moot the issue concerning the amended complaint because, given today's resolution of the res ipsa loquitur issue, the original complaint sufficiently contains [*25] the allegations necessary for plaintiffs to proceed with their claims. In other words, the doctrine of res ipsa loquitur merely provides plaintiff the means to prove the allegations in their original complaint.

Affirmed in part, reversed in part, and remanded for trial. We do not retain jurisdiction.

/s/ Patrick M. Meter

DISSENTBY: Stephen L. Borrello

DISSENT: BORRELLO, J. (*dissenting*).

I respectfully dissent from the opinion issued by Judge Talbot in this case.

Plaintiffs, on behalf of their minor son, brought an action for medical malpractice alleging that while their son Austin was in the care of defendants for retrosyncytial virus (RSV) bronchiolitis, he developed fractures in his right and left femurs. Plaintiffs pleaded that the negligence of defendants was based in part on defendants breaching the standard of care. Because their malpractice claims were initially based on this theory, plaintiffs produced an expert witness who was board certified in pediatrics. Defendant doctor in this case was board certified in pediatrics, pediatric critical care, and neonatology-perinatology. The trial court held that pursuant to *MCL 600.2169(1)(a),* plaintiffs' [*26] expert was not qualified

to testify.

Thereafter, defendants brought a motion pursuant to *MCR 2.116(C)(10)* stating that in the absence of an expert witness, plaintiffs' case must fail as a matter of law. The trial court granted defendants' motion to dismiss. Plaintiffs then brought a motion for leave to amend their complaint pursuant to *MCR 2.118(A)(2)*, claiming that the doctrine of res ipsa loquitur applied in this case. The trial court found that expert testimony was needed to prove res ipsa loquitur, and therefore, any amendment would be futile.

I conclude that the trial court abused its discretion in holding that plaintiffs' expert was not qualified to testify at trial pursuant to *MCL 600.2169(1)(a)*. I further find that no expert testimony was required under the doctrine of res ipsa loquitur as applied to the facts in this case.

Thus, I conclude that because the trial court premised its denial of its motion to amend on an erroneous determination that expert testimony was required, the trial court abused its discretion. I would therefore reverse and remand this matter to the trial court.

I. Issues Presented

The factual issue in this case [*27] concerns when and how Austin's femurs broke. Because the parties conceded at oral argument that there was no definitive evidence regarding how the injuries occurred, this case involves questions of fact that lie solely within the discretion of a jury. On appeal, plaintiffs present the following issues: was plaintiffs' expert qualified to testify, and is expert testimony necessary in a case where an infant is taken to a hospital for treatment of RSV bronchiolitis and somehow develops two broken femurs?

II. Plaintiffs' Expert Witness

In their initial complaint, plaintiffs alleged that defendants breached the standard of care owed to Austin by negligently placing a right arterial line and by leaving Austin lying on his left side too long after placing the left arterial line. Plaintiffs' expert witness was board certified in pediatrics. Defendant Custer was board certified in pediatrics, pediatric critical care, and neonatology-perinatology.

MCL 600.2169(1) provides in relevant part:

> (1) In an action alleging medical malpractice, a person shall not give expert testimony on the appropriate standard of practice or care unless the person [*28] is licensed as a health professional in this state or another state and meets the following criteria:
>
> (a) If the party against whom or on whose behalf the testimony is offered is a specialist, specializes at the time of the occurrence that is the basis for the action in the same specialty as the party against whom or on whose behalf the testimony is offered. However, if the party against whom or on whose behalf the testimony is offered is a specialist who is board certified, the expert witness must be a specialist who is board certified in that specialty.

In *Tate v Detroit Receiving Hosp, 249 Mich. App. 212; 642 N.W.2d 346 (2002)*, this Court held that whether a witness is qualified to serve as an expert witness is within the trial court's discretion, and the trial court's decision in that regard is reviewed for an abuse of discretion. *Id.* at 215. In civil cases, an abuse of discretion is found only in extreme cases where the result is so palpably and grossly violative of fact and logic that it evidences a perversity of will, a defiance of judgment, or the exercise of passion or bias. *Dep't of Transportation v Randolph, 461 Mich. 757, 768;* [*29] *610 N.W.2d 893 (2000); Spalding v Spalding, 355 Mich. 382, 384-385; 94 N.W.2d 810 (1959)*. Thus, the first inquiry is whether the trial court abused its discretion by striking plaintiffs' expert witness.

Plaintiffs contend that because the cause of action in this case centers on the broken femurs Austin allegedly incurred while in defendants' care, their expert was qualified to testify because all that was needed was an expert in general pediatric care. Plaintiffs' expert testified that Austin's fractures could have occurred when defendants positioned him during the insertion of a femoral venous line, a femoral arterial line, or peripheral intravenous lines; when they intubated him; or when they otherwise maneuvered him. Some of these procedures were administered while Austin was in the pediatric intensive care unit at the University of Michigan hospital, and some were not. Both the time and the origin of the injuries are unanswered questions of fact.

Plaintiffs rely on this Court's statement in *Tate, supra,* that an expert's qualifications match every board certification that a defendant physician holds exactly. In *Tate*, we stated: [*30]

> Thus, where a defendant physician has several board certifications and the alleged malpractice involves only one of these specialties, § 2169 requires an expert to possess the same specialty as that engaged in by the defendant physician during the course of the alleged malpractice. [*Tate, supra at 220.*]

In this case, plaintiffs alleged that defendants com-

mitted malpractice when they improperly handled their child. Because nothing in the record requires the conclusion that the broken femurs occurred while defendants were practicing the specialty of intensive pediatric care, such a conclusion can only be reached through conjecture and speculation. The majority admits there is scant evidence regarding when the broken femurs occurred. In the absence of any direct proof regarding when the injury occurred, the trial court abused its discretion by concluding that an expert who was board certified in intensive pediatric care medicine was required.

Thus, I dissent because issues of fact should be decided by juries, not judges. To hold otherwise is to violate the Constitution's guarantee of a right to a trial by a jury. Thomas Jefferson understood that the litmus test [*31] of any democratic society was gauged by the degree to which citizens are given the opportunity of self-government. This meant not only the right to vote, the right to petition the government for redress, but also the right of the populace to sit as jurors. "I consider [trial by jury] as the only anchor ever yet imagined by man, by which a government can be held to the principles of its constitution." Thomas Jefferson to Thomas Paine, 1789. ME 7:408, Papers 15:269. "[The people] are not qualified to judge questions of *law,* but they are very capable of judging question of *fact.* In the form of juries, therefore, they determine all controverted matters of fact, *leaving thus as little as possible,* merely the law of the case, to the decision of the judges." Thomas Jefferson to Abbe Arnoux, 1789. ME 7:422, Papers 15:283 (emphasis added). For the trial court in this matter to have decided that the specialty in question was needed necessarily means that the trial court decided an issue of fact, thereby usurping the role of the jury.

III. Necessity of Expert Testimony under the Doctrine of Res Ipsa Loquitur

Our Courts have long harbored suspicion about the necessity [*32] of experts and their true value to juries. In 1874, our Supreme Court held in *People v Morrigan, 29 Mich. 4, 7 (1874),* that:

> The experience of courts with the testimony of experts has not been such as to impress them with the conviction that the scope of such proofs should be extended. Such testimony is not desirable in any case where the jury can get along without it; and is only admitted from necessity, and then only when it is likely to be of some value. [*Id.*]

Eighty years later, our Supreme Court in *Higdon v Carlebach, 348 Mich. 363, 374, 83 N.W.2d 296* n *; *83 N.W.2d 296 (1957),* commenting on the conclusion reached in *Morrigan, supra,* stated, "It is as true today as it was in 1874." Despite years of warnings from our Courts, our Legislature, by enacting *MCL 600.2169*, necessitated the use of expert witnesses in medical malpractice cases in all but a limited number of instances.

After the trial court dismissed this action, plaintiffs moved to amend their complaint to assert negligence under the doctrine of res ipsa loquitur. Plaintiffs also moved for a determination regarding whether [*33] expert testimony was required considering the facts that had been presented thus far. Plaintiffs argued that there was circumstantial evidence that entitled them to a presumption of negligence. Defendants argued that laypersons could not conclude that this type of injury could have occurred only from defendants' negligence, so expert testimony was necessary to establish that the femur fractures were the result of a breach of the standard of care concerning the manner in which an infant should be handled. The trial court concluded that expert testimony was needed, reasoning that the case involved "medical procedures and the application of those procedures, which information is not within the common knowledge and observation of a reasonably prudent jury." Therefore, citing futility, the court denied plaintiffs' motion to amend.

To prove a medical malpractice claim, a plaintiff must establish the following four factors: (1) the applicable standard of care, (2) breach of that standard of care by the defendant, (3) injury, and (4) proximate causation between the alleged breach and the injury. *Locke v Patchman, 446 Mich. 216, 222; 521 N.W.2d 786 (1994).* [*34] As a general rule, expert testimony is required in medical malpractice cases to establish the applicable standard of care and to demonstrate that the defendant somehow breached that standard. *Birmingham v Vance, 204 Mich. App. 418, 421; 516 N.W.2d 95 (1994),* citing *Bahr v Harper-Grace Hosps, 198 Mich. App. 31, 34; 497 N.W.2d 526 (1993).*

Nonetheless, there are two relevant exceptions to this rule:

> Where the negligence claimed is "a matter of common knowledge and observation," no expert testimony is required. *Daniel v McNamara, 10 Mich. App. 299, 308; 159 N.W.2d 339 (1968).* And, where the elements of the doctrine of res ipsa loquitur are satisfied, negligence can be inferred. *Neal v Friendship Manor Nursing Home, 113 Mich. App. 759; 318 N.W.2d 594 (1982).* [*Thomas v McPherson Center, 155 Mich. App. 700, 705; 400 N.W.2d 629 (1986).]*

Our Supreme Court in *Jones v Porretta, 428 Mich.*

132, 150-151; 405 N.W.2d 863 (1987) adopted the doctrine of res ipsa loquitur when it stated:

> Whether phrased as [*35] res ipsa loquitur or "circumstantial evidence of negligence," . . . it is clear that such concepts have long been accepted in this jurisdiction. The time has come to say so. We, therefore, acknowledge the Michigan version of res ipsa loquitur which entitles a plaintiff to a permissible inference of negligence from circumstantial evidence.
>
> The major purpose of the doctrine of res ipsa loquitur is to create at least an inference of negligence when the plaintiff is unable to prove the actual occurrence of a negligent act. According to Prosser & Keeton, Torts (5th ed), § 39, p 244, in order to avail themselves of the doctrine, plaintiffs in their cases in chief must meet the following conditions:
>
> (1) the event must be of a kind which ordinarily does not occur in the absence of someone's negligence; . . . .
>
> (2) it must be caused by an agency or instrumentality within the exclusive control of the defendant;
>
> (3) it must not have been due to any voluntary action or contribution on the part of the plaintiff. [*Id.*; see also *Wischmeyer v Schanz, 449 Mich. 469, 484 n 29; 536 N.W.2d 760 (1995).]*

Additionally, [*36] our courts have recognized that expert witnesses are not needed in cases where the lack of professional care is so manifest or egregious that a layman could determine the issue of negligence by resorting to common knowledge and experience. See *Roberts v Young, 369 Mich. 133, 138; 119 N.W.2d 627 (1963); Murphy v Sobel, 66 Mich. App. 122, 124; 238 N.W.2d 547 (1975); Burton v Smith, 34 Mich. App. 270, 272; 191 N.W.2d 77 (1971); Haase v DePree, 3 Mich. App. 337, 346; 142 N.W.2d 486 (1966).* For instance, where an instrument is left inside a patient after surgery, no expert testimony is required. *Taylor v Milton, 353 Mich. 421, 425-426; 92 N.W.2d 57 (1958);* see also *Higdon, supra at 374-376* (the defendant dentist drilled on a patient's tongue); *Winchester v Chabut, 321 Mich. 114, 119; 32 N.W.2d 358 (1948); LeFaive v Asselin, 262 Mich. 443, 446; 247 N.W. 911 (1933); Ballance v Dunnington, 241 Mich. 383, 387388; 217 NW 329 (1928)* (the plaintiff suffered [*37] severe burns due to X-ray over-exposure); *Loveland v Nelson, 235 Mich. 623, 624-625; 209 NW 835 (1926)* (the defendant dentist injected Lysol into a patient's gums, mistaking it for anesthetic); *Howard v Park, 37 Mich. App. 496, 502; 195 N.W.2d 39 (1972)* (the plaintiff suffered severe lacerations from a cutting wheel during removal of a leg cast).

In those cases, the courts determined that expert testimony was not a prerequisite to recovery because whether the acts in question were careless and not in accord with standards of good practice in the community was within the common knowledge and experience of the lay jurors. Likewise here, I find that where a child presented to the hospital for RSV bronchiolitis and developed two broken femurs, the doctrine of res ipsa loquitur applies and expert testimony is unnecessary.

Additionally, because we are bound to view the evidence in the light most favorable to the non-moving party, and because defendants presented no contrary evidence, the inference must be granted to plaintiffs that Austin's femurs were healthy at the time of admission. In fact, because Austin was undisputedly [*38] admitted to the hospital for treatment of RSV bronchiolitis and not for treatment of his legs, this case is analogous to the fact pattern set forth in *Higdon, supra.* In *Higdon, supra at 366-367,* a patient was having dentistry performed when the defendant's drill slipped and cut her tongue. Relying upon numerous cases from other jurisdictions, our Supreme Court held that a jury may infer negligence from "lay proof" in cases where "healthy and undiseased parts of the body requiring no treatment are injured during the professional relationship, under circumstances where negligence may legitimately be inferred." *Id. at 374-376.*

In this case, Austin presented to the hospital to be treated for RSV bronchiolitis and subsequently sustained two broken femurs. A lay person can understand that RSV bronchiolitis is not connected to broken femurs and can infer negligence. Expert testimony is not necessary when an injury occurs to a healthy and undiseased body part that did not require treatment. *Higdon, supra at 374-376.* Viewing the evidence in the light most favorable to the nonmoving party, Austin's injuries were to parts of his body which [*39] at the time of admission we must infer were healthy and undiseased. I therefore find our Supreme Court's ruling in *Higdon* controlling. Accordingly, the trial court erred when it held that expert testimony was required.

IV.

Plaintiffs' Right to Amend Their Complaint

The last issue presented on appeal is whether the trial court erred when it denied plaintiffs' motion for leave to amend their complaint. Reviewing this issue for an abuse of discretion, *Dowerk v Oxford Charter Twp, 233 Mich. App. 62, 75; 592 N.W.2d 724 (1998),* I conclude that because the trial court erroneously held that expert testimony was required, it abused its discretion by denying plaintiffs' motion.

MCR 2.118(A)(2) provides that leave to amend a pleading "shall be freely given when justice so requires." Further, "if a trial court grants summary disposition pursuant to *MCR 2.116(C)(8)*, (C)(9), or (C)(10), the court must give the parties an opportunity to amend their pleadings pursuant to *MCR 2.118*, unless the amendment would be futile." *Doyle v Hutzel Hosp, 241 Mich. App. 206, 212; 615 N.W.2d 759 (2000).*

In this case, the trial court found that amendment [*40] would be futile because of an incorrect assertion that plaintiffs had to produce expert testimony to support their claims against defendants. In *Doyle, supra at 220,* this Court concluded that where a court's finding of futility is based on a faulty premise, the court's denial of the motion to amend the complaint constitutes an abuse of discretion. Having found that the trial court based its decision to deny plaintiffs the right to amend their complaint on a faulty premise, I would find that the trial court abused its discretion. I would therefore reverse the ruling of the trial court on all issues presented and remand this matter to the trial court for further proceedings in accordance with this decision.

/s/ Stephen L. Borrello